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ABSTRACT

This report presents patterns and trends in services provided to persons with developmental disabilities through the Washington State Division of Developmental Disabilities (DDD) and related agencies from 1989 through 1994. Following an executive summary, individual chapters provide extensive detail on: (1) the Division and this project; (2) types of services; (3) frequency of services; (4) expenditures for services; and (5) staffing for services. Major findings are reported for frequency of services, expenditures for services, and staffing for DDD residential programs. Findings include: 83 percent of persons eligible for DDD services received services other than DDD case management; community residential services and employment/day programs were the most common DDD services received; 49 percent of individuals in community residential facilities received residential services funded by other divisions; expenditures for community residential, other community services, and personal care for children more than doubled in this period; expenditures per person increased 74 percent for placement support and 43 percent for case management; most of the direct service staff worked at Residential Habilitation Centers (RHCs) and intensive tenant support programs. Appendices provide additional analysis and tables detailing data on methodology, community services by region, respite care in RHCs, expenditures by Center, and staffing by specific residential service. (DB)

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REPORT

PATTERNS AND TRENDS IN SERVICES TO PERSONS ON THE CASELOAD OF THE DIVISION OF DEVELOPMENTAL DISABILITIES

A 5-Year Analysis

(July 1989–August 1994)

EC 304 891

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A 5-Year Analysis

(July 1989-August 1994)

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October 1995

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EXECUTIVE SUMMARY

BACKGROUND

The Division of Developmental Disabilities (DDD) of the Washington State Department of Social and Health Services (DSHS) sponsored a study of services provided to persons with developmental disabilities through the Division and other DSHS agencies, emphasizing services provided through the Aging and Adult Services Administration (AASA) / Home and Community Services (HCS), the Division of Children and Family Services (DCFS), the Division of Vocational Rehabilitation (DVR), the Division of Income Assistance (DIA), and the Medical Assistance Administration (MAA). Additional information is provided, when available, for all DSHS divisions. This report presents patterns and trends in the frequency, expenditures, and staffing for services provided to persons on the caseload of the Division of Developmental Disabilities during State Fiscal Years (SFY) 1990 through 1994 (i.e., July 1, 1989 to June 30, 1994). Additional data for July and August 1994 were included in some analyses to illustrate the impact of recent events.

MAJOR FINDINGS

FREQUENCY OF SERVICES

Service Providers

- 83% of persons eligible for DDD services are receiving DSHS funded services other than DDD case management; 74% of persons on the DDD caseload receive services through other DSHS divisions.

- 48% of persons eligible for DDD services receive no DDD funded services other than case management; 64% of these individuals receive services funded through other DSHS divisions.

- 43% of individuals on the DDD caseload receive services beyond case management through DDD and at least one other DSHS division as well.

- The Medical Assistance Administration (MAA) and the Division of Income Assistance (DIA) provide services to more than half of the DDD caseload.

Division of Developmental Disabilities

- DDD currently operates five RHCs (Interlake closed in June 1994) and state operated living alternative (SOLA) programs in four regions. DDD supports three styles of community living arrangements through private contractors.

- Community residential services and employment/day programs are the most common DDD services received.

- RHC services and facility-based community residential services are reducing, while contracted non-facility based community residential programs (supportive living, tenant support, and intensive tenant support) are expanding.

- Individual supported employment and community access programs expanded over the five-year span (78% and 79%, respectively) due to additional legislative funding for employment and day programs.

- The number of persons on the caseload living in home settings (parent, relative's or adoptive family home) increased 44%, and the number receiving family support services increased 16% since 1990. Respite care is the most common family support service, although the category of other family support services is increasing dramatically (from 10 persons in 1990 to 504 in 1994).

Other DSHS Divisions

- 49% of individuals living in community residential facilities receive residential services funded by other divisions, increasing from 39% in 1990. Foster care and adult family homes are the largest residential programs provided through other divisions.

- DVR provides services to 13% of the persons on the DDD caseload, age 16 or older. The number of DDD caseload members receiving placement support services or vocational assessment and work skill building have more than doubled in the past five years.

- 8% of children enrolled in DDD receive child care services through DCFS (increasing from 5% in 1990) -- a 123% increase

- 66% of persons on the caseload are receiving income assistance. SSI supplements and food stamps are the most common services received by DDD caseload members and their families.

- Over 81% of persons on the DDD caseload received some form of medical assistance through MAA. Most (97%) receive Medicaid and are classified as categorically needy.

- 20% of persons on the DDD caseload received personal care assistance in 1994 (10% of children and 27% of adults). The number of persons receiving Medicaid Personal Care is increasing rapidly (up 127% over 1990 for adults), and particularly among children (from 43 children in 1990 to 866 in 1994).

EXPENDITURES FOR SERVICES

Division of Developmental Disabilities

- DDD currently spends $325 million (SFY 1994) per year, up from $209 million in 1990.

- Expenditures for community residential ($100 million in 1994, up from $78 million in 1991), other community services ($7.7 million, up from $3.1 million), and personal care for children ($2.9 million, up from $59,000) have all more than doubled.

- Median expenditures per person served for personal care for children ($2,715 in 1994, up from $1,050 in 1990), individual supported employment ($3,487, up from $879), respite care ($1,533, up from $824) and other family support ($567, up from a low of $35 in 1991), transportation ($185, up from $86), and professional services paid through supplemental community support ($720, up from $300) each doubled or more in the past five years.

Other DSHS Divisions

- Expenditures for services to persons on the DDD caseload through other DSHS divisions averaged $92 million for 1991 and 1992 (about 1/4 of all DSHS expenditures for persons with developmental disabilities). 42% of dollars spent by other divisions are paid by MAA (an average of $39 million for 1991 and 1992).

- Expenditures per person for DVR services (a total of $5 million in 1994) increased over the five-year span for placement support (74%) and case management (43%).

- Food stamps, AFDC/FIP, and SSI (State Supplement) are the largest DIA expenses for families of persons on the DDD caseload, although only families receiving AFDC/FIP or GAU typically receive more than $1,000 per year through state funds.

- Individuals on the DDD caseload typically receive less than $400 per year in medical assistance. Most (96%) of medical expenditures through MAA are received by individuals on Medicaid.

- Total expenditures for all forms of child care ($1.7 million in 1994) increased 219% since 1990, with expenditures per person for Child Protective Services child care more than doubling (from $360 per child in 1990 to $745 per child in 1994).

- Individuals receiving Medicaid Personal Care receive more than twice as many dollars in 1994 ($3,636) as they received in 1990 ($1,453), with persons living at home receiving seven times more ($4,697, up from $650). Dollars per person for COPES have also almost doubled ($10,234, up from $5,187).

STAFFING FOR DDD RESIDENTIAL PROGRAMS

- Most of the staff serving individuals in DDD provided residential programs are working in RHCs and intensive tenant support programs.

- The number of staff hours per person in SOLA and supportive living programs decreased (by 38% and 15%, respectively), while other community residential programs mildly increased staff hours per person in residence. RHCs, currently (1994) at 13.6 staff hours per person day, increased staff hours per person until 1992 before declining.

CHAPTER 1

INTRODUCTION

THE DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

The Division of Developmental Disabilities (DDD) of the Washington State Department of Social and Health Services (DSHS) provides support services and opportunities for the personal growth and development of persons with developmental disabilities. According to the Revised Code of Washington (RCW 71A.10.020), state residents with a disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or another neurological or other condition closely related to mental retardation or requiring treatment similar to that required for individuals with mental retardation, are eligible for services provided that the disability originated before age 18, is expected to continue indefinitely, and constitutes a substantial handicap. Additionally, children under age 6 may receive services if they have Down Syndrome or have developmental delays of 25% or more below children of the same age. Several forms of services and supports are available to persons with developmental disabilities through DDD and other DSHS divisions. These programs are defined and described in Chapter 2.

The Long Range Strategic Plan for Developmental Disabilities Services (Changes and Challenges in the 1990s, 1993) describes the values and vision of the division as follows.

Values

In addition to following the principles of the Department of Social and Health Services (DSHS) mission, the division also guides its programs and services through service values included in two documents -- Residential Service Guidelines and County Guidelines.

These guidelines address major areas of focus to support individuals with developmental disabilities. They are not listed in any order of priority. A balance among these values is sought for individuals served. For example, both the individual's personal freedom and choice as well as his or her health and safety are often a consideration when planning and delivering services.

The guidelines include:

- **Health and safety**: Feeling safe and secure and being healthy.
- **Personal power and choice**: Making choices and directing our own lives.
- **Status and contribution**: Feeling good about ourselves and having others recognize us for what we contribute to others and our community.
- **Integration**: Being part of our community through active involvement. This means doing things we enjoy as well as new and interesting things.
- **Relationships**: Having people in our lives whom we love and care about and who love and care about us.
- **Competence**: Learning to do things on our own or be supported to do things for ourselves.

Vision

The vision of the Division of Developmental Disabilities embraces the belief that human service systems should be responsive, innovative, flexible and personalized. The division is part of a system that will support, promote and reinforce this vision at all levels of their organization. Their vision is intended to reflect their mission and their values.

The division envisions:

- Assisting communities to build capacity for individuals and families to live in their own homes and neighborhoods.
- Providing individuals with developmental disabilities and their families opportunities to make choices and have control over their lives. To this end, services must be flexible to respond to individual needs.

- Assuring individuals are supported in healthy, safe, caring and appropriate ways regardless of where they live.

- Setting priorities for services and supports based on evaluations of individuals' functional abilities and economic status.

- Encouraging and assisting traditional service programs to develop and deliver "state of the art" services to individuals living in the community.

- Using public dollars in creative, prudent, responsive and flexible ways for the most long-term benefit.

- Planning, developing and managing the system in collaboration and partnership with local communities, private and public agencies, and eligible individuals, their families and advocates.

- Emphasizing high quality management, culturally relevant services, and positive outcomes for individuals who need support; meeting federal and state requirements and involving eligible individuals, their families and advocates in determining and monitoring quality.

PURPOSE AND SCOPE OF THE PROJECT

In an effort to understand the characteristics of persons served and to better coordinate services provided by the division, both in RHCs and in the community, DDD sponsored a series of research studies on the background and changes in characteristics of persons on the caseload and services provided by the division, and estimates of the numbers of persons needing service based on several eligibility criteria. An additional component of the project is to combine information about persons on the caseload, services, and financing for services, from DDD and other DSHS information sources into a composite database from which similar studies and analyses can be conducted in the future, as well as to provide user access for RHCs and community programs.

This report is the second of a series of regular and ad hoc reports scheduled to be produced as a result of this effort. It presents patterns and trends in services provided to persons on the caseload, expenditures for services, and staffing for residential programs during the previous five state fiscal years, but this report is not intended to address the quality of these services. Another report, produced in May 1995, presented patterns and trends in the number and types of persons on the caseload, their demographic characteristics, and the developmental disabilities under which persons are receiving eligibility for services.

METHOD

Analysis

Information was cross tabulated and analyzed to determine changes in services over time, spanning State Fiscal Years 1990 through 1994 (July 1989 through June 1994). Additional data for the months of July and August 1994 were added when necessary to illustrate the effect of the closure of Interlake School on the DDD system. The types of services included in this report are services provided by DDD and their contractors, and additional services provided through the Division of Vocational Rehabilitation, the Aging and Adult Services Administration / Home and Community Services, the Division of Children and Family Services, the Division of Income Assistance, and the Medical Assistance Administration. A few forms of child care provided through the Division of Alcohol and Substance Abuse are also included.

1. **Division of Vocational Rehabilitation (DVR):** All services provided through DVR are included in this report. These services include case management; vocational assessment and work skill building; medical or psychological treatment; education, training, and supplies; personal support services; placement support services; and other services.

2. **Aging and Adult Services Administration (AASA) / Home and Community Services (HCS):** The types of services provided through this division that were selected for inclusion in this report are several forms of residential facilities (adult family homes, nursing facilities, and congregate care facilities) and personal care (Medicaid, Chore services, and the Community Options Program Entry System (COPES)).

3. **Division of Children and Family Services (DCFS):** This division also provides services to many persons who are enrolled in DDD. Of the services offered through this division, foster care (regular and group/treatment) and child care (employment and training, therapeutic, child protective services) were selected for inclusion in this report.

4. **Division of Income Assistance (DIA):** DIA offers several programs to assist persons of low income or disability with obtaining basic necessities. Forms of assistance available include financial supplements, food stamps, child care, employment assistance, and emergency assistance to meet emergent needs. Because information was not available for the entire five-year span due to time

constraints and the large size of this division's data base, a point in time estimate (average for SFY 1991 and 1992) was used to provide a description of the numbers of persons on the DDD caseload receiving services through this division.

5. **Medical Assistance Administration (MAA):** MAA provides assistance with medical bills for many persons enrolled in DDD. For the same reasons as discussed above, point in time estimation was used for services through this division rather than trends over the five-year span.

Services provided through the above divisions were chosen because they serve a large number of persons enrolled in DDD, were of particular interest to the Division, and data were available within a short period of time. Additional information was included on services provided through other DSHS divisions when data were available.

Unless otherwise noted, to obtain counts of the number of persons receiving a service within a year, anyone who received the service at any time during the year was counted as one person, regardless of how much time during the year the service was received. Person counts are unduplicated in the sense that someone who received the same service twice during a single year was only counted as one person. (See Appendix A for details on record unduplication). Dollar amounts include the total expenditure for a particular service, rounded to the nearest $1,000 for total expenditures, and to the nearest dollar for median expenditures per person. Financial information was not adjusted for inflation, so a portion of the increases in expenditures over the five-year span may be attributable to inflation. Staffing is presented in the form of full-time equivalent hours (FTE).

Data Sources and Limitations

Data from the following sources were used in these analyses to collate information on types and costs of services received by persons with disabilities:

1. **DSHS Needs Assessment Client Databases (NADB)**: These are annual person-centered databases created by combining extracts from existing DSHS administrative systems. Individuals who had a DDD service were identified and all their service information was extracted for analysis in this report. All service and expenditure information from SFY 1990 through SFY 1992 included in this report was obtained from NADB, with the following exceptions:

a) DDD case management, for all years, was obtained from the CCDB (see number 2 below)

b) SOLA was not included in the SFY 1990 NADB data base. This information was also obtained from the CCDB

c) Respite care in RHCs was not included in the NADB. The data, for all years, were obtained from the individual facilities

d) Total DDD expenditures and expenditures for employment and day programs, SOLA and RHC were obtained from FRS (see number 8 below)

For SFY 1993 and SFY 1994, service information was obtained from the original source data systems, whose descriptions follow. This includes DDD services and selected AASA/HCS, DCFS, and DVR services provided to persons who were also on the DDD caseload.

2. **DDD Management Information System - Common Client Data Base (CCDB)**: The CCDB allows field personnel to enter and access information about individuals. For this report, data from the CCDB **Residence and Day Program File** were processed. This file identified a person's place of residence (e.g., RHC, community residential, home setting, etc.) and current region or RHC of administrative responsibility, and was the source for data on the following services:

   a) DDD Case Management for SFY 1990 through 1994 (all persons on the caseload who are not living in an RHC received Case Management)

   b) SOLA for SFY 1990, 1993 and 1994 (expenditures from FRS)

   c) RHC for SFY 1993 and 1994 (expenditures from FRS)

   As might be expected, the completeness and timeliness of the CCDB data vary from community to community, thereby causing some problems in regional comparisons and completeness of the data. Data used in the report represent only individuals whose records were entered in the data base as of September 13, 1994. Problems also exist with the data base in terms of incomplete records and inconsistencies in the data record for some persons.

3. **DDD Management Information System - County Human Resources Information System (CHRIS)**: CHRIS allows field personnel to track the type of contracted services received, when the service was received, who provided the service, and how much the service cost. The following contracted services were analyzed using CHRIS data to determine caseload counts and median expenditures per person. Total expenditures information was obtained through FRS (see number 8, below).

a) Community Access services (formerly Senior Citizen and Community Integration services)
b) Child Development services
c) Employment services: Individual Employment, Group Supported Employment, and Special Industries Services

As with the CCDB, the timeliness and completeness of the CHRIS data vary from community to community.

4. **Social Services Payment System - Payment History Files (SSPS-PH)**: Because SSPS-PH is a payment system, its information is relatively complete. This system records the type of service received, when it was received and how much the service cost. The following services provided to persons on the DDD caseload were analyzed using SSPS-PH data from SFY 1993 and 1994:

   a) DDD services: Group Homes, Contracted Non-facility Based Residential, Family Support services, Personal Care for children, and Supplemental Community Support services
   b) AASA/HCS services: Personal Care for adults, COPES, Chore services, Adult Family Homes, and Congregate Care Facilities
   c) DCFS services: Foster Care and Child Care

   Data were extracted from SSPS-PH tapes in November 1994. A small proportion of payments for services received during SFY 1994 were processed after this date. Based on previous years, an estimate of the percentage of services still not entered as of November 1994 is less than one-half of one percent of all SFY 1994 services.

5. **Social Service Payment System - Authorization Files (SSPS-AU)**: Some services are authorized through SSPS but are not paid by SSPS. This system tracks the types of services a person is authorized to receive. For SFY 1993 and SFY 1994, the following AASA/HCS services provided to persons on the DDD caseload were analyzed using SSPS-AU:

   a) Contracted Chore services
   b) Contracted Personal Care services
   c) Nursing Home Facility level care provided in an adult family home or a person's own home (for SFY 1994 only)

   AASA/HCS provided hourly and monthly rates for these authorized services. The number of hours or months for which an individual's service was authorized was multiplied by the appropriate rate to obtain the cost of the service. Although it is possible to determine when a person was authorized for a service not paid by SSPS, it is not possible to determine if the person actually received the service, exactly how much service was received, or exactly when the service was received.

6. **Medicaid Management Information System-Extended Database (MMIS-EDB)**: MMIS-EDB records claim level information on services paid by Medicaid. Information on persons enrolled in DDD was provided to MMIS Evaluation and Medical Review section staff for matching to the MMIS-EDB. Data were obtained for all Medicaid services during SFY 1993 and SFY 1994 that were received by persons enrolled in DDD. The following services were analyzed:

   a) Nursing Homes
   b) ICF/MRs

   As with other billing systems, there is often a lag in the MMIS-EDB between the time when a service is provided and the time when the payment is processed. However, because of the nature of the services analyzed for this report (monthly payments for a relatively stable population) the impact on the data is insignificant.

7. **Division of Vocational Rehabilitation Integrated Client System (DVR-ICS)**: DVR staff provided data on all DVR services to persons they identified as being on the DDD caseload. All of these persons were reported as having received DVR case management services. Most services provided and paid for by DVR were included in this report. The time the case manager spent on the participant's behalf and any services facilitated by the case manager, but not paid for by DSHS, are not included.

8. **DSHS Financial Reporting System (FRS)**: FRS receives data from the Washington State Agency Financial Reporting System (AFRS), and it contains expenditure and staffing information that can be aggregated in various ways, including RHC and Community, and which can be subtotaled by community residential and other community services. The following FRS data were used in this report for all five fiscal years:

   a) Expenditures: RHC, SOLA, employment and day programs, total DDD expenditures, and total expenditures for community programs by region
   b) Staffing: RHC, SOLA and field service office staff FTEs

DDD staff provided ORDA with the aggregated expenditure and staffing data used in this report. FTEs were computed from the actual total person months worked during the fiscal year, divided by 12. These counts include paid overtime, but do not include non-paid exchange time or compensatory time.

9. **DDD Contract Rate Files**: DDD maintains information regarding their contracts for the operation of community residential programs (i.e., Group Homes, ICF/MRs, Tenant Support, Intensive Tenant Support, and Supportive Living). The following contract data, provided by DDD staff, were used in this report:

   a) Direct care staff hours per person day
   b) Direct care staff FTEs

   The data provided are from contracts in place on July 1 of each year and are used as indicators of staff levels for the previous fiscal year. For example, the information for contracts from July 1, 1992 are shown as Fiscal Year 1992. The data from the contracts are for direct care staff only; administrative and support staff are not included. Additionally, staffing data are contracted amounts and may differ slightly from the actual number of hours worked.

ORGANIZATION OF THE REPORT

The findings of the study are presented in the following four chapters.

- **Chapter 2** lists the various services persons on the DDD caseload may receive through DDD and through other DSHS divisions. Services discussed in this report are defined and described.

- **Chapter 3** explores the types of services persons on the DDD caseload are receiving through the Division and through other DSHS divisions, and examines changes over time in the types of services provided.

- **Chapter 4** presents expenditures for the various services received by persons on the DDD caseload, paid for both by DDD and by other DSHS divisions.

- **Chapter 5** discusses staffing levels for various residential programs operated by DDD and other private agencies contracted through DDD. Staffing at community service offices is also discussed in a related appendix.

CHAPTER 2

TYPES OF SERVICES

Persons eligible for services through the Division of Developmental Disabilities may receive a variety of services. The following summary describes the services available through the Division, as well as select services received by persons on the DDD caseload through the Aging and Adult Services Administration / Home and Community Services, the Division of Vocational Rehabilitation, the Division of Children and Family Services, the Division of Income Assistance, and the Medical Assistance Administration that were received by a large number of persons on the DDD caseload and were chosen by DDD to be explored.

CASE/RESOURCE MANAGEMENT

Once eligibility is determined, a case manager is assigned to each person. He/she assesses the needs of the individual and family, then links these needs to available services. Additional specific responsibilities of case managers include:

A. Developing individual service plans
B. Authorizing payment for publicly funded services
C. Arranging delivery of needed public benefits and services
D. Monitoring and coordinating service delivery
E. Providing support for the individual and family
F. Providing information and making referrals
G. Assisting community agencies
H. Providing crisis intervention

Once the individual and/or his or her family's needs have been assessed and a plan has been developed, the case manager's continued involvement with the person varies considerably. When needed services or supports are not available, the eligible individual may be placed on a waiting list. For individuals who are not currently in need of services, the case manager may not be in contact with the person on an annual basis, yet the person may remain on the DDD caseload. Conversely, some eligible persons are in urgent need of services or may be in crisis, requiring daily contact with the case manager.

RESIDENTIAL HABILITATION CENTERS (RHC)

Operated by the Division, the RHCs provide a protected living environment and a comprehensive array of services within a single setting. Services are based on individual habilitation plans, and typically include basic care, habilitation, training, adult education, therapies and health; 24-hour nursing, medical and dental care; and life enrichment activities including organized recreation and leisure. Currently, there are five state operated residential facilities; all serve persons with a range of disabilities.

A. **Fircrest School**: Providing service for over 35 years, Fircrest, in North Seattle, received nursing home certification to serve individuals with developmental disabilities in 1973 and began operating as an ICF/MR in 1977. Persons are divided into three organizational units, called Program Area Teams (PAT), with two functioning under ICF/MR regulations (284 beds) and the third under nursing home standards (108 beds). The interdisciplinary team develops and integrates individual treatment plans into normal daily living, and ensures the delivery of active treatment. Maxin School serves persons under age 21, while an Adult Training Program provides training and habilitation services for persons 21 years and older.

B. **Lakeland Village**: Once known as the State Custodial School, Lakeland Village was opened in 1915 at Medical Lake as the first developmental disabilities institution in the state. A total of 243 persons are served under ICF/MR regulations, while the rest (60) are served under nursing facility standards. In addition to residential services, Lakeland provides respite care for persons on the DDD caseload living in the community, and professional assessment and treatment services throughout Region 1.

C. **Frances Haddon Morgan Center**: Originally opened in 1972 to serve children with autism, Frances Haddon Morgan Center in Bremerton currently provides residential support for children, adolescents, and adults. Individualized services and supports are provided for persons with autism and related developmental disabilities. The Center receives state-wide referrals, and provides health, professional, educational, and employment support. This center also provides respite care and evaluations for persons on the DDD caseload living in the community.

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D. **Rainier School**: Located in Buckley, Rainier was opened in 1939 as the second developmental disabilities facility in the state. Its population increased from 172 in 1940 to a peak of 1,839 in 1960, declining to 802 in 1980, and about 470 in 1994. It became an ICF/MR in 1978/79. Programs at Rainier are organized into units, also called PATs, with habilitation, training, and other services provided by interdisciplinary teams specializing in individualized care for persons with similar needs.

E. **Yakima Valley School**: Yakima Valley School was established in 1958 in Selah (near Yakima), and for many years it was the only program for children with developmental disabilities serving Central Washington. It originally served persons of all ages who were multiply handicapped and severely or profoundly retarded. Currently, most of the persons being served at Yakima Valley School are non-ambulatory, and it is certified as a nursing facility.

A sixth residential habilitation center, **Interlake School**, opened in 1968 at Medical Lake, was closed on June 30, 1994.

COMMUNITY RESIDENTIAL SERVICES

These services are provided to persons who require assistance with daily living and do not live at home with their own family. Individuals live among the general public in homes located in residential neighborhoods.

DDD Provided Services

DDD contracts directly with numerous organizations and individuals to provide persons in community living situations with varying levels of assistance in daily living.

Licensed Facility-Based Programs

In facility-based residential programs, room and board are included in the rate paid by DDD. Persons living in these situations contribute to State provided room and board. In these programs, persons do not own, lease, rent or otherwise have control over the physical space in which they live. Their service providers are also their landlords.

A. **Group Homes**: These facilities range in size from 3 to 35 persons, with about 70% housing no more than eight people. Group homes provide on-site supervision during all hours persons are in the house.

B. **Intermediate Care Facilities for the Mentally Retarded (ICF/MR)**: Commonly called IMRs, these group living situations (4-63 persons) provide training, therapy, and habilitation in compliance with federal ICF/MR regulations. These programs typically include more intensive nursing, therapy services, psychological and social services, and recreation. Several of these facilities are licensed as nursing homes or boarding homes.

Services in People's Homes

These programs provide support and assistance to persons living in their own home or apartment. In these programs, the Division pays for staffing support and individuals pay for their rent, food, and other expenses. Often several persons live together as roommates. In contrast to facility-based programs, the individuals served do own, lease or rent the physical space in which they live. The service provider does not function as the landlord in these situations; services are brought into the person's home.

A. **Supportive Living**: Alternative Living, Tenant Support, and Intensive Tenant Support are services designed for people who require assistance to live in their community. These programs are staffed through private agencies contracted by DDD. Staff are available in person or by phone, and provide direct training and assistance to the participant on a flexible schedule according to individual needs, ranging from 24 hours per day for some persons to several hours per month for others. Supports are typically provided to assist with household and money management, personal health, use of community resources, and development of community and social integration experiences.

B. **State Operated Living Alternative (SOLA)**: State employees provide support and supervision in some intensive tenant support programs (i.e., State Operated Living Alternatives, commonly called SOLAs). These programs, which began in SFY 1990, are similar to those described above, the only difference being that state employees are involved rather than contracted employees and all persons receive 24 hours of support and supervision per day.

Other DSHS Facilities

Residential supports provided by other DSHS divisions are all provided in settings other than the individual's own home.

Aging and Adult Services Administration (AASA) / Home and Community Services (HCS)

A. **Adult Family Home (AFH)**: These homes are small group care settings for as many as six adults per home. Persons residing in these homes can not live alone, but do not need skilled nursing care. Services provided include room and board, laundry, and support in community and family activities.

B. **Nursing Home Services**: In these residential facilities, staff perform an array of services for persons with disabilities who require daily nursing care, as well as assistance with medication, eating, dressing, walking, or other personal needs.

C. **Congregate Care Facility (CCF)**: These facilities, licensed as boarding homes, provide 24-hour supervision of, and help with, the following life tasks for adults: Activities of daily living, planning medical care, taking medications, and the handling of financial matters when necessary.

Division of Children and Family Services

A. **Foster Care**: These services are provided to children who cannot live with their parents and therefore need short-term or temporary care. Children live in the home of licensed foster parents who care for the child until the legal parent or guardian can resume care taking responsibilities.

B. **Group/Treatment Foster Care**: Group Care, Treatment Foster Care, and Special Models of Group Care are foster care arrangements serving children with emotional and/or behavioral difficulties which exceed the service or supervision capability of regular foster care families. Care occurs in facility-based settings rather than family homes. Length of stay in these settings typically range from 3 to 18 months.

EMPLOYMENT/DAY PROGRAMS

Most children and approximately half of adults, including most of those adults receiving residential services from DDD, are involved in some type of day program. For many people, these programs are paid for through the Division of Developmental Disabilities. DDD provides funds to county governments who select and contract with service providers. These services assist individuals with employment related support and assistance, and with learning personal and vocational skills that will help them adjust and integrate into the community at large and gain more independent functioning. Services include:

A. **Child Development Services**: Designed to maximize a child's developmental potential, these services include therapy, education, family counseling, and parent training. Children and their families receive these services from birth until age three, when they become eligible for services provided through public schools.

B. **Employment Services**: For many adults, DVR funds the initial job development and job training costs for 6 to 9 months; DDD then provides on-going support to help the person maintain his/her job. DVR and the counties, who administer DDD employment programs, enter into interagency agreements to work out the funding coordination. Three types of employment programs are contracted.

  1) ***Individual Employment*** programs assist persons with developmental disabilities with finding and keeping jobs in community settings. These programs match participant interests and skills to available community jobs, provide extensive on-the-job training, train supervisors and co-workers to work with a person with developmental disabilities, and provide ongoing support.

  2) ***Group Supported Employment*** programs enable individuals to work in community settings in supervised groups of no more than eight workers with developmental disabilities. Supervisors are available full-time to provide training and support.

  3) ***Specialized Industries*** programs provide employment training in a sheltered workshop setting. Individuals typically participate in such programs five days per week, four to six hours per day.

C. **Community Access Services:** Community Access programs cover a diverse range of social, communication, leisure and employment activities, and assist persons with developmental disabilities with gaining access to community activities in which people without disabilities also participate. These services include activities, special assistance, advocacy and education individualized to promote growth and personal relationships.

DIVISION OF VOCATIONAL REHABILITATION

The Division of Vocational Rehabilitation (DVR) administers a set of programs which encompass the vocational rehabilitation of persons with physical, mental or sensory disabilities which affect their work opportunities. Several persons on the

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DDD caseload participate in these programs which are co-funded by DDD and DVR (see Employment Services, above). DVR provides the initial training and upfront costs of placing a person in an employment program, then DDD provides continued support and assistance. The types of services persons on the DDD caseload receive through DVR include the following.

A. **Case Management**: All persons on the DDD caseload who received services through DVR were identified as having received case management services. Participants who are employable without ongoing follow-up after rehabilitation are helped by DVR case managers to assess job skills, access community resources, and prepare for suitable employment. Additionally, DVR case managers, as part of a larger team, assist participants who require ongoing follow-up and post-employment services with maintaining employment. Team members outside DVR provide long-term follow-up and post-employment services.

B. **Vocational Assessment & Work Skill Building**: These services include the identification of a participant's interests, readiness for employment, work skills, and job opportunities.

C. **Medical or Psychological Treatment**: Included in this group of services are any restorative medical or psychological treatments which are needed to increase work potential and/or job accessibility. Examples include surgery, prostheses, hospital and convalescent care, and the purchase of necessary medical equipment.

D. **Education, Training & Supplies**: DVR also pays for direct costs of vocational training. These costs include tuition, school books and equipment, interpreter or reader services, and lab fees.

E. **Personal Support Services**: These services help the participant complete a rehabilitation plan and find employment. Examples include help with transportation costs, day care, independent living services, purchase of tools or equipment, and the alteration or repair of a vehicle so that a participant can get to work.

F. **Placement Support Services (Work Support)**: This group of services is specific to job placement and includes the purchase of clothing, tools, or equipment necessary for job placement; assistance with resumes, job applications, business licenses and fees; and job placement fees.

G. **Other Services**: Miscellaneous participant necessities can also be provided to assist participants with their job search and employment.

DIVISION OF INCOME ASSISTANCE

The Division of Income Assistance (DIA) and Economic and Medical Field Services (EMFS) provide welfare grants, food assistance, related employment training, and child care payments to low-income persons, including those who have disabilites and are unemployable. Throughout this report, these two entities are referred to as "Income Assistance" or "DIA". Several programs provide services to persons of low income requiring financial assistance. Both federal and state funds are used to support these programs.

A. **Aid to Families with Dependent Children (AFDC)**: Low income families with children under 18 years of age can receive cash assistance for food, clothing and shelter. Additional payments can be authorized for laundry, telephone, restaurant or home-delivered meals, food for a guide dog and home winterization.

B. **Family Independence Program (FIP)**: FIP was a five-year demonstration by the state of Washington as an alternative to the current welfare system, specifically to AFDC and Food Stamps, to demonstrate that families can get off welfare and become self-sufficient through employment. FIP enrollees are families who would have been eligible for the AFDC program and, consequently, share the same characteristics as the AFDC population. Families may receive:

1) Food assistance in the form of cash rather than food stamps
2) Personalized help in accessing social services
3) Assessment of work skills and career potential
4) Opportunities to participate in education or training programs
5) Local labor market information and referral to job openings
6) Help with child care costs while at work or participating in training
7) Cash incentives for participating in training or employment
8) One year of transitional benefits in the form of medical care and child care assistance when they are earning a high enough level of income to make them ineligible for cash assistance.

C. **Supplemental Security Income (SSI)**: Persons who are blind, older than age 65, or permanently disabled receive state supplements to the federal social security benefit rate up to the state's SSI standard for financial assistance. Additional money may be provided for telephone, laundry, meals on wheels, restaurant meals and food for guide dogs. The state supplement also pays additional costs for clothing and personal incidental needs of SSI recipients in nursing homes.

D. **General Assistance Unemployable (GA-U)**: Persons of low income who are unemployable due to physical, mental or emotional incapacity can receive cash grants for food, clothing and shelter through this program if the incapacity is not sufficiently continuous or long-lasting for SSI, or the person is awaiting SSI determination. These individuals also receive casework services to aid in gathering medical reports, referrals for proper treatment, and assistance with the SSI application/appeals process; and referrals for alcohol/drug addiction assessment and eligibility determination for the Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) program. This program is fully funded by the State.

E. **Food Stamp Program (FSP)**: All low-income persons, without restrictions based on age, incapacity, or household composition, can receive coupons redeemable for food items. FIP grant recipients receive cash instead of food coupons. This program is funded through a 100% federal match, with 50% federal funds for administration.

F. **Other DIA Services**: Other services offered through DIA during the time span covered in this report include cash grants to low income pregnant woman, refugees, and US repatriates; financial assistance to those with emergent needs; funeral and interment assistance for those who cannot afford costs; and waivers or discounts on telephone service. This division also operates the Job Opportunities and Basic Skills training program (JOBS) for AFDC applicants and recipients; components include assessment, job readiness, education, jobs skills training, volunteer work, work experience, on-the-job training, job search, and job placement.

MEDICAL ASSISTANCE ADMINISTRATION

The Medical Assistance Administration (MAA) provides medical coverage for necessary health care services to persons of low income who are refugees, who have disabilities, are pregnant or raising children under age 18. Medical assistance is provided to several groups of persons.

A. **Medicaid**: Medicaid is the largest funding source, covering about 95% of all persons receiving medical assistance. Funding for these services is shared by both federal and state contributions. Two major groups of persons receive Medicaid.

1) ***Categorically needy*** individuals meet financial and other program requirements.

2) ***Medically needy*** persons meet non-financial requirements, but have either excess resources or family incomes slightly above categorically needy limits. These persons become eligible for coverage, for a three or six month period, once they have obligated themselves to spend excess income or resources on medical care during the period.

B. **GA-U and ADATSA**: Persons enrolled in GA-U and ADATSA who are not eligible for Medicaid can receive medical assistance through this state funded program.

C. **Others**: Other persons who can receive assistance with medical bills are refugees during their first eight months following arrival in the United States (federal funds), children from low income families not eligible for Medicaid (state funds), and medically indigent persons not eligible for other programs (state funds, for emergency medical care only).

FAMILY SUPPORT SERVICES

Families of individuals with developmental disabilities can be provided with support so that the person with disabilities can live at home. Family support is provided in the home of the individual's natural (immediate or extended) or legal (adoptive) family. Support services provided through DDD include:

A. **Respite Care**: In or out-of-home respite care provides the family with short-term assistance in the care of their son or daughter.

B. **Attendant Care**: In-home attendant care or personal care services help families provide ongoing care for persons who have major physical or behavioral needs.

C. **Transportation**: Transportation for attendants or family members can be provided to take persons with developmental disabilities to their appointments and day programs.

D. **Professional Support Services**: Children and their families can receive behavioral consultation/counseling and physical, occupational, instructional and communication therapies paid through family support funding. Other therapies may also be received by exception request.

E. **Other Family Support Services**: Miscellaneous family-based services can also be provided; for example, specialized aids or equipment, and reimbursements for activity fees and training materials.

OTHER COMMUNITY SERVICES

DDD Provided Services

When individuals with developmental disabilities live apart from their families, they are eligible for several services to assist their daily living. These services are paid through the Division of Developmental Disabilities, and include the following.

A. **Attendant Care**: In home care can be provided on either a temporary or an ongoing basis. DDD can provide temporary additional staffing to enable a person to remain in his/her home and avoid out of home placement during a period of illness or other crisis.

B. **Transportation**: These services provide assistance to persons with developmental disabilities with transportation to their appointments and work related or day programs.

C. **Professional Services**: Individuals living apart from their families can receive several types of professional services paid through supplemental community support funds. Included in this category are psychological services used to determine eligibility, the developmental disabilities professional (DDP) evaluations required by courts, and counseling and other therapeutic services for adults in DSHS and DDD funded residential settings, or in their home.

D. **Supplemental Community Support**: This group of services includes community services oriented toward persons with developmental disabilities; such as, interpreters and translators, summer recreational activities, equipment purchases, and reimbursement for activity fees.

E. **Medicaid Personal Care for Children**: This federally funded program provides help with activities of daily living to children with disabilities who need assistance to remain living with their natural family. DDD determines eligibility and handles the accounting for children on their caseload who are receiving support through this program.

Other DSHS Divisions

In addition to those services provided by other DSHS divisions that have already been discussed, the following types of services are also provided to persons on the DDD caseload through other DSHS divisions.

A. Child Care

A variety of forms of child care are provided to families through other DSHS divisions. Families and their children may receive one of several forms of child care.

1) ***Employment & Training***: Provided through DCFS, this form of child care assists custodial parent(s) who are working or in secondary education and who earn less than 52% of the State Median Income adjusted for family size.

2) ***Therapeutic***: Also provided through DCFS, children who are at risk for child abuse and neglect can receive this form of child care assistance.

3) ***Child Protective Services***: Children whose families need respite, treatment, or parent education can receive this form of child care through DCFS.

4) ***Income Assistance***: Child care assistance through the Division of Income Assistance is available to families on Aid to Families with Dependent Children (AFDC) or the Family Independence Program (FIP) when a parent/guardian is working, participating in a department-approved education/training/JOBS component, or is no longer eligible for grant assistance for earnings-related reasons.

5) ***Other Child Care***: Several other forms of child care are available. These include seasonal day care, provided through DCFS, with a priority on serving children of farm workers, and Division of Alcohol and Substance Abuse (DASA) therapeutic child care and day care.

B. Personal Care

1) ***Medicaid Personal Care for Adults***: This federally funded program, as described above for children, provides help with activities of daily living to adults with disabilities who need assistance to remain in their own homes, Adult Family Homes (AFH), or Congregate Care Facilities

(CCF). DDD determines eligibility for Medicaid Personal Care for adults, and AASA handles the accounting for adult Medicaid recipients.

2) ***Chore Services***: Offered through AASA/HCS, this state funded program provides in-home personal care services to non-Medicaid eligible persons with disabilities who are living in their own homes.

3) ***Community Options Program Entry System (COPES)***: Also a service of AASA/HCS, this program assists individuals to delay or avoid nursing home placement by providing for the coordinated delivery of support services necessary for persons with disabilities to remain in less restrictive settings and avoid more costly out-of-home placements. Services provided include case management, in-home personal care, congregate care, respite care, and adult family home care.

CHAPTER 3

FREQUENCY OF SERVICES

SERVICE PROVIDERS

Table 3-1: Location of Services for DDD Caseload (SFY 1991-1992)

Service Provider		Average
Case Management Only	N	3,239
	%	17.4
DDD Services Only	N	1,614
	%	8.7
SSI/Medical	N	1,207
	%	6.5
Other DSHS Services	N	602
	%	3.2
DDD +Other DSHS Services Only	N	512
	%	2.8
SSI/Medical + DDD Services	N	2,765
	%	14.9
SSI/Medical + Other DSHS Services	N	3,938
	%	21.2
SSI/Medical + DDD + Other DSHS Svcs	N	4,695
	%	25.3
Average DDD Caseload	N	18,569

Note: DDD services refer to all services provided in addition to case management.

Note: Other DSHS Services includes persons who received DDD case management in addition to a service from some other non-DDD division.

Note: SSI/Medical refers to persons who received either SSI payments or medical assistance.

All persons on the DDD caseload receive some level of case management services through the Division of Developmental Disabilities (DDD), but many persons also receive other services through DDD or through other divisions of the Department of Social and Health Services. The numbers reported in Table 3-1 are the average

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number of persons served during state fiscal years 1991 and 1992[1]. In total, 52% of persons eligible for DDD services are receiving some service other than case management through the Division, and 74% of persons on the DDD caseload are receiving services through other divisions of the Department of Social and Health Services (DSHS).

Over 17% of persons enrolled as eligible for services through the division receive only DDD case management and no services from any other DSHS division (see Table 3-1). Many of these persons want and need services but cannot obtain them due to the division's limited resources and long waiting lists, and many others do not desire any additional services beyond case management. 26% of persons on the caseload receive services through the Division of Developmental Disabilities and no services from any other DSHS division. Many of these persons may be children receiving such services as family support and Medicaid Personal Care for children, which are administered through DDD.

Although almost half (48%) of persons on the DDD caseload receive no services from DDD other than case management, 64% of these persons (or 29% of the DDD caseload) are receiving services through other divisions (see Table 3-1). Many persons receive services through multiple divisions. 43% of persons on the DDD caseload receive case management plus other services through DDD plus additional services through other DSHS divisions.

Medical and SSI payments are common services for person on the DDD caseload to receive through other divisions. For instance, 68% of persons on the DDD caseload receive SSI supplements through the Division of Income Assistance (DIA) and/or medical assistance through the Medical Assistance Administration (MAA). 7% of the DDD caseload receives case management and SSI and/or medical benefits, but no other DDD or other DSHS services; 15% receive another DDD service with their case management and SSI/medical assistance; while 21% receive other DSHS services in addition to case management and SSI/medical assistance but no other DDD services, and 25% are receiving case management, SSI/medical assistance, and another DDD service, and another DSHS service.

Among those persons on the DDD caseload who are not receiving SSI or medical assistance, 3% received another DSHS service in addition to case management but no other DDD service, and 3% received both a DDD service and another DSHS service in addition to case management.

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[1] A total listing of services provided to persons on the DDD caseload was only available through the Needs Assessment data bases, which only covers state fiscal years 1990 to 1992. Since the data are most complete in this data base for SFY 1991 and 1992, an average of the numbers provided through this data base was used to estimate the numbers of persons receiving services through DDD or through other DSHS divisions. Recent data are not readily available for all DSHS divisions.

Table 3-2: Services Provided Through the Division of Developmental Disabilities

Service		Fiscal Year 1990	1991	1992	1993	1994	5 Year % Change
RHC	N	1,796	1,691	1,595	1,503	1,469	
	%	10.8	9.7	8.5	7.5	6.8	-18.2
Community Residential	N	3,385	3,609	3,664	3,621	3,723	
	%	20.3	20.6	19.6	18.0	17.1	10.0
Employment/Day Programs	N	-----	-----	-----	7,985	8,118	
	%	-----	-----	-----	39.7	37.3	-----
Family Support	N	1,874	1,980	1,781	1,998	2,176	
	%	11.2	11.3	9.5	9.9	10.0	16.1
Other Community Services	N	1,950	2,400	2,426	2,251	2,235	
	%	11.7	13.7	13.0	11.2	10.3	14.6
Personal Care for Children	N	43	146	315	566	866	
	%	0.3	0.8	1.7	2.8	4.0	1,914.0
Total DDD Caseload	N	16,662	17,511	18,728	20,130	21,738	30.5

Note: Employment/Day program numbers are omitted for SFY 1990-1992 because the number of persons in child development programs are not available from the data source for these years

Note All programs are not necessarily available to all age groups. Data are divided into the appropriate age groups in the individual program tables that follow

- The number of persons receiving services through RHCs is declining, while all other DDD services are increasing.

- Personal Care for Children is the DDD program growing at the fastest rate; the only program that is growing faster than the caseload growth rate.

- The most common services persons on the caseload receive through DDD are employment and day programs, followed by community residential services.

- Personal Care for Children and RHCs are the services received by the smallest number of persons. Also, only a small percentage of persons receive family support or other community services.

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OTHER DSHS DIVISIONS

All divisions of the Department of Social and Health Services provide services to at least some persons on the DDD caseload, and some provide services to more than half of DDD's caseload (see Table 3-3).

Table 3-3: Services to DDD Caseload Through Other Divisions [2] (average of SFY 1991-1992)

Division		Average
AASA/HCS	N	3,215
	%	17.3
DASA	N	79
	%	0.4
DCFS	N	1,840
	%	9.9
DIA	N	9,910
	%	53.4
DORA	N	61
	%	0.3
DVR	N	1,386
	%	7.5
JRS	N	11
	%	0.1
MAA	N	12,173
	%	65.6
MHD	N	1,789
	%	9.6
Average DDD Clients	N	18,569

- Common services for persons on the DDD caseload to receive through other divisions are Medicaid Personal Care for adults through AASA/HCS; Medicaid Personal Care for children on the DDD caseload in Foster Care, day care, and CPS services through DCFS; Aide for Families with Dependent Children (AFDC) through DIA; education, training, and supplies through DVR; medical coupons through MAA, and mental health services through MHD.

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[2] AASA/HCS = Aging and Adult Services Administration and Housing and Community Services. AASA is the administrative portion of this division and HCS provides field services.
DASA = Division of Alcohol and Substance Abuse
DCFS = Division of Children and Family Services
DIA = Division of Income Assistance
JRS = Juvenile Rehabilitation Services
DORA = Division of Refugee Assistance
DVR = Division of Vocational Rehabilitation
MAA = Medical Assistance Administration
MHD = Mental Health Division

- The Medical Assistance Administration (MAA) provides services to two-thirds of the DDD caseload, and the Division of Income Assistance (DIA) provides services to more than half of the DDD caseload.

- The Aging and Adult Services Administration (AASA) / Home and Community Services (HCS), the Division of Children and Family Services (DCFS), the Division of Vocational Rehabilitation (DVR), and the Mental Health Division (MHD) each provide services to between 7% and 17% of the DDD caseload.

- A few persons on the DDD caseload are served by the Division of Alcohol and Substance Abuse (DASA), Juvenile Rehabilitation Services (JRS), or the Division of Refugee Assistance (DORA).

Since income and medical assistance are the services most commonly provided to persons on the caseload through other DSHS divisions, the Division of Income Assistance and the Medical Assistance Administration are explored in more detail later in this report.

Table 3-4: Community Residential Services[3]

		Community Residential		Fiscal Year 1990	1991	1992	1993	1994	5 Year % Change
DDD Provided	Facility Based	Group Home	N	885	839	812	761	749	
			%	59.6	62.5	68.9	69.8	72.9	-15.4
		ICF/MR	N	604	509	371	329	279	
			%	40.7	37.9	31.5	30.2	27.1	-53.8
		Total Facility Based	N	1,485	1,343	1,179	1,090	1,028	
		% Community Res.	%	-----	22.4	19.1	15.9	14.8	-30.8
	Non-Facility Based	Supportive Living	N	-----	2,391	2,510	2,491	2,653	
			%	-----	97.6	97.2	96.7	96.4	-----
		SOLA (State ITS)	N	25	60	74	87	101	
			%	-----	2.4	2.9	3.4	3.7	304.0
		Total Non-Facility Based	N	-----	2,451	2,581	2,577	2,753	
		% Community Res.	%	-----	40.9	41.7	37.7	39.5	-----
		Total DDD Comm. Res.	N	3,385	3,609	3,664	3,621	3,723	10.0
Other DSHS Facilities		Adult Family Home	N	736	810	879	1,027	1,151	
			%	35.7	31.4	32.7	30.8	34.0	56.4
		Nursing Home	N	335	628	573	676	676	
			%	16.3	24.3	21.3	20.3	20.0	101.8
		Congregate Care Facility	N	387	430	397	425	406	
			%	18.8	16.6	14.8	12.7	12.0	4.9
		Total Foster Care	N	675	846	958	1,277	1,228	
			%	32.8	32.8	35.7	38.3	36.3	81.9
		Total Other DSHS	N	2,059	2,583	2,687	3,336	3,381	
		% Community Res.	%	-----	43.1	43.5	48.8	48.5	64.2
		Total Community Res.	N	-----	5,995	6,183	6,834	6,967	-----
Total DDD Comm. Adults 18+			N	8,881	9,577	10,310	11,018	11,829	
% Group Home			%	10.0	8.8	7.9	6.9	6.3	
% ICF/MR			%	6.8	5.3	3.6	3.0	2.4	
% Supportive Living			%	-----	25.0	24.3	22.6	22.4	
% SOLA			%	0.3	0.6	0.7	0.8	0.9	
% Adult Family Home			%	8.3	8.5	8.5	9.3	9.7	
% Nursing Home			%	3.8	6.6	5.6	6.1	5.7	
% Congregate Care			%	4.4	4.5	3.9	3.9	3.4	
Total DDD Comm. Children <18			N	6,324	6,601	7,166	7,947	8,908	
% Foster Care			%	10.7	12.8	13.4	16.1	13.8	
Total DDD Community Caseload			N	14,960	15,923	17,222	18,662	20,374	
% in Community Residential			%	-----	37.6	35.9	36.6	34.2	

Note: Values for SFY 1990 are missing from the Supportive Living category because the data for Region 4 in that year were tracked through the county rather than through SSPS.

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[3] For SFY 1993 and SFY 1994, the total facility based, total other DSHS, and total community residential values may be slightly high because the source for ICF/MR and nursing home counts (MMIS) was not unduplicated with SSPS (the source for the other community residential programs). Using the SFY 1992 NADB the estimated effect of the duplication is as follows. No overlap occurred between ICF/MRs and group homes, so the total facility based values may not have been affected. A 0.5% overlap between nursing homes and other non-DDD DSHS facilities occurred, so the total other DSHS values may be approximately 3 persons too high in each year for SFY 1993 and SFY 1994. A 2.0% overlap between ICF/MRs, nursing homes and other community residential facilities indicates that the total Community residential values for SFY 1993 and SFY 1994 may be approximately 20 persons too high in SFY 1993 and SFY 1994.

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- Among adults enrolled in DDD, supportive living arrangements are the most common type of community residential service (22% of adults enrolled in DDD and living in the community are served by these programs). Other programs serve less than 10% of the adults in the DDD community caseload, with the SOLA program serving less than 1% of these adults. Among children, 13% were living in foster care arrangements during some time in SFY 1994.

- The number of persons receiving facility based placements through DDD is declining -- from 22% in SFY 1991 to 15% in SFY 1994. Although, the number of persons receiving non-facility based placements through DDD or facility based placements through other divisions is increasing.

- Of persons receiving community residential placements, 49% receive these services through facilities administered by other DSHS divisions. This percentage has been increasing at least since SFY 1991, and DDD has no oversight of the quality of these programs.

- Foster care (36% in SFY 1994) and adult family home placements (34% in SFY 1994) are the most common forms of community residential services provided to persons on the DDD caseload through other DSHS divisions.

- The number of persons living in congregate care facilities varies from year to year, declining from 19% in SFY 1990 to 12% in SFY 1994. The number of persons on the DDD caseload living in nursing homes (20% in SFY 1994) increased, particularly between SFY 1990 and SFY 1991. People were not added to nursing homes in those years, but people living in nursing homes were evaluated for DDD eligibility in SFY 1991 due to a policy change, and thus were entered into the caseload of the Division of Developmental Disabilities.

- Group homes are the largest type of facility based community residential program in the DDD system (73% of DDD facility based placements in SFY 1994). The number of persons living in this type of facility is reducing at a slower rate than the number of persons living in community based ICF/MRs.

- Nearly all persons in non-facility based DDD residential placements are receiving services through contracted providers. Few people are living in SOLA arrangements, although the numbers are increasing. Additional persons were added to SOLA arrangements during the last budget cycle in an effort to make them more efficient in terms of per capita costs.

Foster Care

Two forms of foster care are available to children: regular foster care and group treatment foster care. The following analyses explore the frequency of foster care services provided to children who are enrolled in DDD by type of care.

Table 3-5a: Children Receiving Foster Care

		Fiscal Year					5 Year %
Foster Care		1990	1991	1992	1993	1994	Change
Regular Foster Care	N	651	812	917	1,202	1,148	
	%	96.4	96.0	95.7	94.1	93.5	76.3
Group/Treatment Foster Care	N	51	86	95	156	155	
	%	7.6	10.2	9.9	12.2	12.6	203.9
Total Foster Care	N	675	846	958	1,277	1,228	
% in Foster Care	%	10.7	12.8	13.4	16.1	13.8	81.9
Total DDD Comm. Children < 18	N	6,324	6,601	7,166	7,947	8,908	40.9

- On average, 13% of the children in DDD are in foster care placements during some portion of the year.
- The number of children from DDD placed in regular foster care increased 76% over SFY 1990, while the number of children placed in group or treatment foster care has more than tripled since SFY 1990.
- The growth rate for the number of children receiving foster care is more than double the growth rate for children in the DDD system; although, more children were in foster care during SFY 1993 than in SFY 1994.

Table 3-5b: Children Receiving Foster Care (Average Monthly Count)

	Fiscal Year					5 Year %
Foster Care	1990	1991	1992	1993	1994	Change
Regular	455	579	670	828	762	67.5
Group/Treatment	35	50	58	97	103	194.3
Total Foster Care	486	615	712	900	843	73.5

- The average number of children on the DDD caseload in foster care on a monthly basis is generally about 70% of the annual total number. That is, a portion of children are not in foster care for an entire year.

- The trends for average monthly counts are similar to those noted above for the annual totals.

EMPLOYMENT AND DAY PROGRAMS

Table 3-6: Employment and Day Programs

Employment/Day Program		Fiscal Year 1990	1991	1992	1993	1994	5 Year % Change
Child Development	N	-----	-----	-----	2,561	2,581	
% Caseload 0-2	%	-----	-----	-----	91.3	85.2	-----
Total DDD Comm. Caseload 0-2	N	2,340	2,490	2,638	2,806	3,029	
Individual Supported Employment	N	1,120	1,303	1,703	2,147	2,106	
	%	27.6	30.8	35.6	39.6	38.0	88.0
Group Supported Employment	N	1,026	1,103	1,206	1,192	1,195	
	%	25.3	26.1	25.2	22.0	21.6	16.5
Special Industries	N	1,842	1,781	1,803	1,714	1,677	
	%	45.4	42.1	37.7	31.6	30.3	-9.0
Community Access	N	650	715	865	1,108	1,203	
	%	16.0	16.9	18.1	20.4	21.7	85.1
Total Adult Employ/Day	N	4,058	4,232	4,777	5,424	5,537	
% of Caseload 21+	%	50.9	48.7	50.9	53.9	51.6	36.4
Total DDD Comm. Caseload 21+	N	7,978	8,685	9,386	10,059	10,741	

Note: Numbers of children receiving child development programs were not available in the data source prior to SFY 1993

Therefore, totals and percentages could not be computed for these years

- Half of the adults enrolled in DDD receive some type of employment or day program. The numbers of persons receiving individual supported employment and community access services are increasing at the fastest rate. Although, the rate of growth for individual supported employment slowed in recent years, dropping in SFY 1994, while the rate continued to grow throughout the span for community access programs.

- The number of persons receiving group supported employment increased slightly between SFY 1990 and SFY 1992, and the number of persons receiving specialized industries services declined slightly after SFY 1992.

- Today (SFY 1994), employment programs are the most common type of day program for persons on the DDD caseload to receive (4,978 persons), followed by child development services (2,581 children, 85% of all children enrolled and younger than age 3) and community access programs (1,203 persons).

- Specialized industries used to be the most common form of employment program, but individual supported employment is now the largest employment program, with 20% of adults enrolled in DDD (38% of adults receiving an employment or day program) receiving individual supported employment.

DIVISION OF VOCATIONAL REHABILITATION

Table 3-7: DVR Services Provided to Persons on the DDD Caseload

		Fiscal Year					5 Year %
DVR Services		1990	1991	1992	1993	1994	Change
Case Management	N	1,218	1,288	1,483	1,501	1,793	
	%	100.0	100.0	100.0	100.0	100.0	47.2
Vocational Assessment & Work Skill Building	N	202	221	242	299	502	
	%	16.6	17.2	16.3	19.9	28.0	148.5
Medical or Psych. Treatment	N	491	463	519	749	640	
	%	40.3	35.9	35.0	49.9	35.7	30.3
Education, Training & Supplies	N	559	419	447	633	850	
	%	45.9	32.5	30.1	42.2	47.4	52.1
Personal Support Services	N	111	96	128	142	192	
	%	9.1	7.5	8.6	9.5	10.7	73.0
Placement Support Services	N	307	225	335	440	670	
	%	25.2	17.5	22.6	29.3	37.4	118.2
Total DDD Caseload in DVR	N	1,218	1,288	1,483	1,501	1,793	47.2
% of DDD Caseload 16+	%	13.2	12.9	13.8	13.0	14.4	
Total DDD Comm. Caseload 16+	N	9,253	9,976	10,783	11,581	12,476	34.8

Note: Only persons age 16 and older on the DDD caseload are included in the total because this is the age at which DVR can begin serving individuals.

- The numbers of individuals on the DDD caseload who are receiving services provided through DVR has generally been increasing, from 1,218 in SFY 1990 to 1,793 in SFY 1994. On average, 13% of individuals on the DDD caseload, age 16 or older, also receive services through DVR.

- The numbers of these persons who received vocational assessment and work skill building, personal support services, and placement support services increased at the fastest rate over the five-year span, with the numbers receiving vocational assessment and work skill building and placement support more than doubling.

- All persons enrolled in both the DDD and DVR systems are receiving DVR case management. Other common services for persons on the DDD caseload to receive are education, training, and supplies (850 persons in SFY 1994); placement support services (670 persons); medical or psychiatric treatment (640 persons); and vocational assessment and work skill building (502 persons).

DIVISION OF INCOME ASSISTANCE

Table 3-8: DIA Services Provided to Persons on the DDD Caseload[4] (average of SFY 1991-1992)

Service		Average
AFDC/FIP	N	1,078
	%	10.9
SSI	N	7,369
	%	74.4
GAU	N	279
	%	2.8
Food Stamps	N	3,795
	%	38.3
Other DIA Services	N	1,447
	%	14.6
Average DDD Persons in DIA	N	9,910
% of DDD Total Caseload	%	59.8
Average DDD Comm. Caseload	N	16,573

- 60% of the DDD caseload receives some assistance through the Division of Income Assistance (DIA). The most common service persons on the DDD caseload receive through DIA is Supplemental Security Income (SSI).

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[4] A total listing of DIA services provided to persons on the DDD caseload was only available through the Needs Assessment data bases, which only covers state fiscal years 1990 to 1992. Since the data are most complete in this data base for SFY 1991 and 1992, an average of the numbers provided through this data base was used to estimate the numbers of persons receiving services through DIA.

- Many families with a member eligible for DDD services receive food stamps (38%) and cash assistance (11%) through Aid to Families with Dependent Children (AFDC) or the Financial Independence Program (FIP).

- Only a small percentage of persons on the DDD caseload (3%) receive financial assistance through General Assistance-Unemployable.

MEDICAL ASSISTANCE ADMINISTRATION

Table 3-9: MAA Services Provided to Persons on the DDD Caseload[5] (average of SFY 1991-1992)

	Service		Average
Medicaid	Categorically Needy	N	11,698
		%	98.7
	Medically Needy	N	282
		%	2.4
	Total Medicaid	N	11,855
		%	97.4
Other MAA	GAU/ADATSA	N	122
		%	1.0
	Others Receiving Medical Assistance	N	4,249
		%	34.9
Totals	Average DDD Persons in MAA	N	12,174
	% of DDD Total Caseload	%	73.5
	Average DDD Comm. Caseload	N	16,573

- Over 73% of persons on the DDD caseload receive some form of medical assistance through the Medical Assistance Administration (MAA).

- Most of the persons enrolled in DDD and receiving medical assistance receive assistance through Medicaid, with less than 36% receiving assistance through other types of programs.

- Of those receiving Medicaid, almost all are classified as "categorically needy."

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[5] A total listing of MAA services provided to persons on the DDD caseload was only available through the Needs Assessment data bases, which only covers state fiscal years 1990 to 1992. Since the data are most complete in this data base for SFY 1991 and 1992, an average of the numbers provided through this data base was used to estimate the numbers of persons receiving services through MAA.

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FAMILY SUPPORT SERVICES

Table 3-10: Family Support Services

		Fiscal Year					5 Year %
Family Support Services		**1990**	**1991**	**1992**	**1993**	**1994**	**Change**
Respite	N	1,669	1,721	1,536	1,665	1,738	
	%	89.1	86.9	86.2	83.3	79.9	4.1
Attendant Care	N	202	231	228	206	223	
	%	10.8	11.7	12.8	10.3	10.2	10.4
Transportation	N	132	216	194	141	137	
	%	7.0	10.9	10.9	7.1	6.3	3.8
Professional Services	N	232	319	269	304	390	
	%	12.4	16.1	15.1	15.2	17.9	68.1
Other Family Support	N	10	25	36	177	504	
	%	0.5	1.3	2.0	8.9	23.2	4,940.0
Total Family Support	N	1,874	1,980	1,781	1,998	2,176	16.1

- The total number of persons receiving family support services has changed only mildly over the five-year span since this program is frozen. Each of these services was frozen in terms of authorizations during much of the time span; however, the freeze was temporarily lifted periodically to allow new entrances from waiting lists. Also, the numbers in the table represent actual services rather than authorizations; that is, if a person was authorized to receive services but didn't actually receive the service, she/he is not included in these counts. These two explanations account for the variation in numbers from year to year in spite of this program being frozen.

- The number of persons receiving other family supports (purchase of specialized aids or equipment and reimbursements to providers for out-of-pocket expenses purchased for caseload members, such as activity fees and training materials) has increased dramatically over the five-year span (particularly since SFY 1992), with 23% of individuals who received family support receiving these forms of support in SFY 1994 (up from less than 1% in SFY 1990). The increase is largely due to changes in the program that allow families greater flexibility in choosing how to spend their family support dollars.

- The number of persons receiving professional support paid through family support funding is also increasing strongly -- from 232 persons in SFY 1990 to 390 persons in SFY 1994. These services include behavioral consultation/counseling and physical, occupational, and communication therapies provided to children and their families through Family Support funding. This increase is also largely due to persons selecting to spend their family support dollars in this way.

- The most common form of family support is respite care (80% of family support services in SFY 1994). However, the percentage of persons receiving this form of family support is declining as other forms of family support are provided more frequently.

Individuals living in a parent, relative's or adoptive family home are eligible to receive a variety of family support services, as discussed above. However, more people are authorized for family support services than actually receive it. The following analyses compare the number of persons eligible to receive family support to the number of persons actually receiving this form of support.

Table 3-11: Number of Persons Receiving Family Support

	Fiscal Year					5 Year %
Persons Living at Home	1990	1991	1992	1993	1994	Change
Receiving Family Support	1,874	1,980	1,781	1,998	2,176	
% Receiving Family Support	18.9	18.7	15.4	15.6	15.2	16.1
Total Living at Home	9,923	10,598	11,596	12,838	14,279	
% Comm Caseload	66.3	66.6	67.3	68.8	70.1	43.9
Total Comm Caseload	14,960	15,923	17,222	18,662	20,374	36.2

- There has been a consistent increase in the number of persons living in a home setting every year over the five-year span, with an increase of 7-11% more individuals per year.

- A larger percentage of all persons on the community caseload are living in home settings each year (70% in SFY 1994, up from 66% in SFY 1990), as opposed to living in an RHC or community residential program.

- 15-16% of individuals living at home received some form of family support in recent years (SFY 1992-1994). This is a slightly smaller percentage than were receiving family support in the early years of the five-year span (19%). This change reflects budgetary constraints, but not necessarily a change in the type of programs families need and want. Additionally, decreased usage of family support needs to be considered in context with the increased usage of Medicaid Personal Care (see Tables 3-16a and 3-16b); which also addresses many of the needs addressed through DDD family support programs.

Respite Care

The following analyses explore the most common form of family support, respite care, in more depth. Respite care can occur in or out of a person's home. Information on respite care at specific RHCs is discussed in Appendix B.

Table 3-12: Location of Respite Care

		Fiscal Year					5 Year % Change
Location		1990	1991	1992	1993	1994	
RHC	N	10	21	28	31	38	280.0
	%	0.6	1.2	1.8	1.8	2.1	
Community	N	1,669	1,721	1,536	1,665	1,738	4.1
	%	99.4	98.8	98.2	98.2	97.9	
Total Respite	N	1,679	1,742	1,564	1,696	1,776	5.8

- Most persons (98% in SFY 1994) who receive respite care receive it in the community.

- The number of persons receiving respite care in RHCs increased (from 10 to 38 persons) between SFY 1990 and SFY 1994, but is still very small in relation to community-based respite care.

Information on the length of respite care stays was only available for RHCs, so the following analyses refer to RHC respite care stays only.

Table 3-13: Length of Respite Care Stays in RHCs (Total Stays Over 5 Year Span)

Length of Stay (Days)	Number of Stays	% of Stays
1-3	147	39.6
3-8	185	49.9
9-15	5	1.3
16 or more days	34	9.2
Total Stays	371	100.0

- Respite care is a temporary, short-stay program, with 89% of stays lasting a week or less.

- 40% of respite care stays were only one to three days long, and 87% of those occurred over a weekend.

OTHER COMMUNITY SERVICES

Table 3-14: Other Community Services

	Other Community Services		Fiscal Year 1990	1991	1992	1993	1994	5 Year % Change
DDD Provided	Attendant Care	N	-----	364	361	374	384	
		%	-----	2.3	2.1	2.0	1.9	-----
	Transportation	N	793	1,270	1,222	905	941	
		%	5.3	8.0	7.1	4.8	4.6	18.7
	Professional Services	N	934	920	949	946	937	
		%	6.2	5.8	5.5	5.1	4.6	0.3
	Supplemental Community Support	N	600	639	618	565	573	
		%	4.0	4.0	3.6	3.0	2.8	-4.5
	Total Community Caseload	N	14,960	15,923	17,222	18,662	20,374	
Other DSHS	Child Care	N	330	414	477	735	737	
		%	2.2	2.6	2.8	3.9	3.6	123.3
	Personal Care Assistance Adults	N	1,737	2,197	2,427	2,827	3,233	
		%	11.6	13.8	14.1	15.1	15.9	86.1
	Other AASA/HCS	N	382	531	520	-----	-----	
		%	2.6	3.3	3.0	-----	-----	-----
	Other DCFS	N	555	1,042	1,307	-----	-----	
		%	3.7	6.5	7.6	-----	-----	-----
Total DDD Community Caseload		N	14,960	15,923	17,222	18,662	20,374	36.2

Note: Numbers of persons receiving attendant care were not separated from supplemental community support in the data source for SFY 1990

Note: Data on number of persons receiving other services through AASA/HCS and DCFS were not available after SFY 1992

Note: The totals for child care do not include income assistance child care and other child care. See note on Table 3-15

Nore: Personal care assistance for adults includes Medicaid, Chore, and COPES

- The numbers and percentages of persons receiving other community services provided through DDD varies from year to year, with transportation assistance and professional services being the most common service types (5% of persons on the DDD community caseload during SFY 1994).

- Of the services provided through other DSHS divisions, child care and personal care assistance are increasing strongly, with the number of persons receiving child care services more than doubling in the past five years, and the number of persons receiving personal care assistance increasing by 86%.

- An average of 3% of persons on the DDD community caseload received other services provided through the Aging and Adult Services Administration / Home and Community Services between SFY 1990 and SFY 1992 beyond those specifically mentioned in this report. These services include adult protective services, case management and comprehensive adult assessment.
- An increasing percentage of persons on the DDD caseload received other services through the Division of Children and Family Services between SFY 1990 and SFY 1992. These services include child protective services, family reconciliation services, first steps social services, home based services, interim care services, adoption and adoption support.

Since a large number of individuals on the DDD caseload receive child care services and personal care assistance services through other divisions, the following analyses explore these services in more depth.

Child Care Services

Table 3-15: Child Care Services

Child Care		Fiscal Year 1990	1991	1992	1993	1994	5 Year % Change
Employment & Training	N	79	127	168	264	293	
	%	23.9	30.7	35.2	35.9	39.8	270.9
Therapeutic	N	71	95	89	138	146	
	%	21.5	22.9	18.7	18.8	19.8	105.6
Child Protective Services	N	228	256	285	459	417	
	%	69.1	61.8	59.7	62.4	56.6	82.9
Income Assistance	N	89	98	157	-----	-----	
	%	27.0	23.7	32.9	-----	-----	-----
Other Child Care	N	9	14	22	-----	-----	
	%	2.7	3.4	4.6	-----	-----	-----
Total Child Care	N	330	414	477	735	737	
% Receiving Child Care	%	5.2	6.3	6.7	9.2	8.3	123.3
Total DDD Comm. Children <18	N	6,324	6,601	7,166	7,947	8,908	40.9

Note: Numbers of children receiving income assistance child care and other child care were not available for SFY 1993 and 1994.

Because of this, these children are not included in the total for any year.

- 8% of children on the DDD caseload during SFY 1994 were receiving child care services through DSHS. The number of children receiving these services more than doubled in the past five years.

- Employment and training child care is increasing at the fastest rate among all forms of child care provided through DSHS to children on the DDD caseload. The number of children receiving therapeutic child care has also more than doubled over the five-year span, and the number of children on the DDD caseload participating in CPS child care has also increased strongly (83%).

Personal Care Assistance

Children may receive personal care assistance through Medicaid Personal Care for Children, a program administered by DDD. Adults may receive several other forms of personal care assistance, all of which were administered through other DSHS divisions during the five-year span. For these reasons, personal care assistance for children and for adults are treated separately in the following analyses.

Table 3-16a: Personal Care Assistance for Children

		Fiscal Year					5 Year %
Personal Care		1990	1991	1992	1993	1994	Change
Medicaid Personal Care for Children	N	43	146	315	566	866	
% receiving Medicaid Personal Care	%	0.7	2.2	4.4	7.1	9.7	1,914.0
Total DDD Children < 18	N	6,324	6,601	7,166	7,947	8,908	40.9

- The number of children on the DDD caseload receiving Medicaid Personal Care for Children has shown explosive growth, with over 20 times as many children receiving this form of support in SFY 1994 than in SFY 1990; although, currently (SFY 1994) less than 10% of children enrolled in DDD are receiving this form of support.

Table 3-16b: Personal Care Assistance for Adults[6]

	Personal Care		1990	1991	1992	1993	1994	5 Year % Change
			Fiscal Year					
Adult Medicaid	Home	N	899	745	972	1,173	1,646	
	% Adults	%	10.1	7.8	9.4	10.6	13.9	83.1
	Congregate Care Facility	N	199	269	264	293	306	
	% Adults	%	2.2	2.8	2.6	2.7	2.6	53.8
	Adult Family Home	N	628	749	786	931	1,102	
	% Adults	%	7.1	7.8	7.6	8.4	9.3	75.5
	DDD Adult Comm. Caseload 18+	N	8,881	9,577	10,310	11,018	11,829	33.2
	Total Adult Medicaid Prsn. Care	N	1,261	1,683	1,886	2,235	2,860	
	% Personal Care Assistance	%	72.6	76.6	77.7	79.1	88.5	126.8
Chore	Individual Provider	N	568	456	469	528	336	
		%	100.0	85.7	85.9	86.6	82.8	-40.8
	Agency	N	-----	83	84	86	77	
		%	-----	15.6	15.4	14.1	19.0	-----
	Total Chore	N	568	532	546	610	406	
	% Personal Care Assistance	%	32.7	24.2	22.5	21.6	12.6	-28.5
COPES	COPES	N	102	83	96	91	91	
	% Personal Care Assistance	%	5.9	3.8	4.0	3.2	2.8	-10.8
Totals	Total Personal Care Assist. Adults.	N	1,737	2,197	2,427	2,827	3,233	
	% Caseload	%	19.6	22.9	23.5	25.7	27.3	86.1
	Total Comm. Caseload 18+	N	8,881	9,577	10,310	11,018	11,829	33.2

Note: Numbers for State provided Chore services were not available for SFY 1990 in the data source.

Note: Medicaid totals and Total Personal Care assistance total does not include Medicaid Personal Care for Children.
See Table 3-2 and 3-16a for these numbers.

- 27% of adults enrolled in DDD were receiving personal care assistance services in SFY 1994, up from 20% in SFY 1990. This rate of increase is similar to the adult community caseload growth rate.

- A larger percentage of adults receiving personal care assistance are receiving Medicaid Personal Care each year -- 73% in SFY 1990 (first year this program was in place), increasing to 89% in SFY 1994. This is the most common funding source for personal care assistance.

- The largest portion of Chore services are received through individual providers rather than agencies, and the total number of persons receiving Chore services varies from year to year; though declining in percentage from 33% in SFY 1990

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[6] The total for Medicaid Personal Care additionally includes persons who received personal care assistance during transfer from an ICF/MR. There were 3 such persons in SFY 1990, 6 in SFY 1991, 9 in SFY 1992, 10 in SFY 1993, and 11 in SFY 1994.

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to 13% in SFY 1994. This decline is largely due to the increased use of Medicaid Personal Care.

- Only a small percentage of personal care assistance services are provided through COPES (3% in SFY 1994), and a smaller percentage of persons are receiving these services each year (down from 6% in SFY 1990) as well.

CHAPTER 4

EXPENDITURES FOR SERVICES

The following analyses explore expenditures for services provided through the Division of Developmental Disabilities, their contractors, and other DSHS divisions. Each group of expenditures is analyzed in two tables: The first table lists total expenditures for services by fiscal year in thousands of dollars, and the second table lists median expenditures per person per year in dollars. Because expenditures vary widely from individual to individual, median expenditures give a better estimate of the cost of services per person -- 50% of individuals received more than this amount and 50% of individuals received less than this amount. The total rows in the median expenditures per person tables are median expenditures for all persons who received a particular service and are not totals of the rows in the table.

Expenditures per person for RHC and SOLA programs were not available; therefore, daily rates were obtained from the Division of Developmental Disabilities and expenditures per person for a fiscal year were calculated by multiplying the daily rate by the number of days an individual was in residence.

Information was available on expenditures for RHCs by center and total expenditures for DDD community services by region. Expenditures for RHCs by center are presented in Appendix C, and expenditures for DDD community services by region are presented in Appendix D.

Table 4-1a: Expenditures for Services Provided Through the Division of Developmental Disabilities (in thousands)

Service		Fiscal Year 1990	1991	1992	1993	1994	5 Year % Change
Total RHC Dollars	$	121,166	140,861	153,904	153,448	146,421	
	%	58.0	51.9	50.4	44.6	45.1	20.8
Community Residential	$	-----	78,079	88,715	98,546	98,710	
	%	-----	72.5	72.4	70.1	70.3	-----
Employment/Day Programs	$	16,918	18,154	20,645	27,996	25,654	
	%	-----	16.9	16.9	19.9	18.3	51.6
Family Support	$	3,611	4,635	5,041	4,953	5,435	
	%	-----	4.3	4.1	3.5	3.9	50.5
Other Community Services	$	3,111	6,435	7,119	7,099	7,715	
	%	-----	6.0	5.8	5.1	5.5	148.0
Personal Care for Children	$	59	416	942	1,966	2,894	
	%	-----	0.4	0.8	1.4	2.1	4,805.1
Total Comm Dollars	$	-----	107,719	122,462	140,560	140,408	
% DDD Dollars	%	-----	39.7	40.1	40.9	43.3	-----
Total DDD Dollars	$	208,975	271,344	305,176	343,766	324,519	55.3

Note: The value for community residential services in SFY 1990 was removed from this table because some of the data for programs were not available for that year.

Note: RHC dollars are from FRS and do not include IMR tax.

Note: Total DDD dollars are from FRS and are not the sum total of dollars in this table.

- Expenditures for other community services and personal care for children have more than doubled in the last five years, although these programs are still a small percentage of the total dollars spent.

- RHCs and employment and day programs both experienced decreases in total expenditures in SFY 1994 as compared with SFY 1993.

- RHCs still account for the largest single category of DDD expenditures (45%); however, total RHC dollars are now similar to total dollars spent on DDD community programs since expenditures for community programs have been increasing at a much faster rate than expenditures for RHCs.

Table 4-1b: Median Expenditures per Person for Services Provided Through the Division of Developmental Disabilities (in dollars)

	Fiscal Year					5 Year %
Service	1990	1991	1992	1993	1994	Change
Median $ RHC	72,099	97,721	113,919	112,099	111,544	54.7
Community Residential	-----	14,090	16,841	19,797	19,907	-----
Employment/Day	-----	-----	-----	3,055	2,730	-----
Family Support	929	1,287	1,680	1,567	1,763	89.8
Other Community	300	450	440	478	510	70.0
Personal Care Children	1,050	2,114	2,035	2,753	2,715	158.6
Median $ Community	-----	1,653	1,969	2,534	2,812	-----

Note: Employment/Day program numbers are omitted for SFY 1990-1992 because the expenditures for clients in child development programs were not available from the data source for these years.

Note: The value for community residential services in SFY 1990 was removed from this table because some of the data for programs were not available for that year.

Note: Daily rates are provided in Appendix C for RHCs and Appendix D for Community expenditures.

- Median expenditures per person for every DDD funded service have increased over the five-year span, with expenditures for personal care for children more than doubling (increases occurred between SFY 1990 and SFY 1991, and again between SFY 1992 and SFY 1993).

- Most programs have experienced strong increases in median expenditures per person. However, median expenditures per person at RHCs have declined since SFY 1992, and median expenditures for employment and day programs declined in SFY 1994.

- As a category, RHCs are the most expensive service offered to individuals on the DDD caseload on a per-person basis, while other community services cost comparatively little per person. These services, however, differ greatly in what is provided to people and thus are not directly comparable.

OTHER DSHS DIVISIONS

Table 4-2: Average Expenditures for Services Provided Through Other Divisions (SFY 1991-1992, in thousands)[1][2]

Division		Average
AASA/HCS	$	21,535
	%	23.4
DASA	$	76
	%	0.1
DCFS	$	10,766
	%	11.7
DIA	$	5,894
	%	6.4
DORA	$	4
	%	0.0
DVR	$	2,351
	%	2.6
JRS	$	129
	%	0.1
MAA	$	39,035
	%	42.4
MHD	$	12,356
	%	13.4
Average Dollars	$	92,146

- Average total expenditures by other DSHS divisions for persons enrolled in DDD were over $92 million. Thus, about one-quarter of DSHS expenditures for persons with developmental disabilities are paid for by other divisions.

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[1] AASA/HCS = Aging and Adult Services Administration and Housing and Community Services. AASA is the administrative portion of this division and HCS provides field services.
DASA = Division of Alcohol and Substance Abuse
DCFS = Division of Children and Family Services
DIA = Division of Income Assistance
JRS = Juvenile Rehabilitation Services
DORA = Division of Refugee Assistance
DVR = Division of Vocational Rehabilitation
MAA = Medical Assistance Administration
MHD = Mental Health Division

[2] A total listing of expenditures for services provided to persons on the DDD caseload was only available through the Needs Assessment data bases, which only covers state fiscal years 1990 to 1992. Since the data are most complete in this data base for SFY 1991 and 1992, an average of numbers provided through this data base was used to estimate expenditures for persons receiving services through DDD or through other DSHS divisions. Recent data are not readily available for all DSHS divisions.

- 42% of expenditures by other divisions were paid through the Medical Assistance Administration (MAA) for Medicaid paid medical services.

- Over 23% of other division expenditures were from the Aging and Adult Services Administration (AASA) / Home and Community Services (HCS). Of these, 52% were for nursing homes and another 40% were for personal care services.

- 12% of expenditures by other divisions were from the Division of Children and Family Services (DCFS). Of these, 82% were for foster care.

- Of the $12.4 million paid by the Mental Health Division (MHD), 45% were for individuals residing in Western and Eastern State Hospitals (average 181 persons per year). Another 45% were for case management, outpatient and day treatment.

Table 4-3a: Expenditures for Community Residential Services (in thousands)

				Fiscal Year					4 Year % Change	5 Year % Change
		Community Residential		1990	1991	1992	1993	1994		
DDD Provided	Facility Based	Group Home	$	10,965	14,225	14,241	15,299	15,686		
			%	38.0	44.0	46.9	47.8	54.2	10.3	43.1
		ICF/MR	$	17,901	18,077	16,114	16,686	13,253		
			%	62.0	56.0	53.1	52.2	45.8	-26.7	-26.0
		Total Facility Based	$	28,865	32,302	30,355	31,985	28,939		
		% DDD Community Res.	%	-----	41.4	34.2	32.5	29.3	-10.4	-----
	Non-Facility Based	Supportive Living	$	-----	39,731	50,552	57,698	61,079		
			%	-----	86.8	86.6	86.7	87.5	53.7	-----
		SOLA (State ITS)	$	889	6,046	7,808	8,863	8,692		
			%	-----	13.2	13.4	13.3	12.5	43.8	877.7
		Total Non-Facility Based	$	-----	45,777	58,360	66,561	69,771		
		% DDD Community Res.	%	-----	58.6	65.8	67.5	70.7	52.4	-----
		Total DDD Comm. Res.	$	-----	78,079	88,715	98,546	98,710	26.4	-----
		% Total Community Res.	%	-----	79.4	79.7	77.4	76.6		
Other DSHS Facilities		Adult Family Home	$	-----	475	430	509	578		
			%	-----	2.4	1.9	1.8	1.9	21.7	-----
		Nursing Home	$	6,093	11,312	11,443	15,431	16,743		
			%	-----	56.0	50.8	53.6	55.4	48.0	174.8
		Congregate Care Facility	$	741	763	720	766	780		
			%	-----	3.8	3.2	2.7	2.6	2.2	5.3
		Foster Care - Regular	$	4,887	7,657	9,954	12,110	12,107		
		& Group/Treeatment	%	-----	37.9	44.1	42.0	40.1	58.1	147.7
		Total Other DSHS	$	-----	20,207	22,547	28,816	30,208		
		% Community Res.	%	-----	20.6	20.3	22.6	23.4	49.5	-----
		Total Community Res.	$	-----	98,286	111,262	127,362	128,918	31.2	-----

Note: Values do not include Medicaid Personal Care add ons. These are state contributions only.

Note: Dollars for ICF/MR programs do not include IMR tax.

Note: Supportive Living includes alternative living, tenant support, and intensive tenant support. SOLA is an intensive tenant support program only.

Note: The value for supportive living is missing for SFY 1990 because the data for Region 4 were tracked through the county rather than through SSPS in that year.

Note: The value for adult family homes has been removed for SFY 1990 because this service was authorized differently in SSPS after this year.

Note: % change is based on both 4 year and 5 year time interval in this table. Because of unusal data points for several programs in SFY 1990, the four year estimate of change may be more accurate for planning purposes than the five year estimate.

- Total community residential expenditures have increased by 31% in the past 4 years (though increasing only 1% between SFY 1993 and SFY 1994). Increases in expenditures for DDD provided programs (26% increase) have been lower than increases for other DSHS facilities (50% increase).

- The expenditures for total DDD facility based programs have dropped to 29% of total DDD community residential expenditures, down from 41% in SFY 1991.

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During the same time, the percentage of DDD expenditures for non-facility based programs rose.

- The gap in expenditures between group homes and ICF/MRs is closing, from a $4 million difference in SFY 1991 to over a $1 million difference in SFY 1994, with expenditures for ICF/MRs being less than those for group homes in SFY 1994. Several ICF/MRs closed in SFY 1994 and the persons living in these facilities moved into other residential services, primarily intensive tenant support programs, a form of supportive living.

- SOLA, which began in SFY 1990, accounts for 12% of DDD non-facility based community residential program expenditures (SFY 1994). The majority of expenditures for non-facility based residential assistance are paid to contracted providers of supportive living programs (alternative living, tenant support, intensive tenant support).

- Although there have been clear trends for expenditures in DDD provided community residential programs, the pattern of expenditures for most community residential programs managed by other DSHS divisions was variable.

- Expenditures for persons living in nursing homes increased by 48%, and by 58% for foster care; although, the rate of increase for foster care leveled off in SFY 1994. Patterns of expenditures over 5 years for nursing homes and foster care have increased strongly as the number of persons in residence increased (see Table 3-4).

Table 4-3b: Median Expenditures per Person for Community Residential Services (in dollars)

			Fiscal Year					4 Year % Change	5 Year % Change
		Community Residential	1990	1991	1992	1993	1994		
DDD Provided	Facility Based	Group Home	11,032	15,725	16,593	18,399	18,206	15.8	65.0
		ICF/MR	32,111	39,526	45,609	50,621	47,035	19.0	46.5
		Median Facility Based	17,600	21,353	21,912	24,149	22,420	5.0	27.4
	Non-Facility	Supportive Living	-----	10,626	10,753	11,372	11,422	7.5	-----
		SOLA (State ITS)	35,797	112,886	101,960	105,146	89,870	-20.4	151.1
		Median Non-Facility Based	-----	10,626	10,753	11,372	15,598	46.8	-----
Other DSHS	Facilities	Adult Family Home	-----	400	298	258	251	-37.3	-----
		Nursing Home	19,412	19,813	21,960	24,588	26,556	34.0	36.8
		Congregate Care Facility	2,407	2,127	2,192	2,262	2,260	6.3	-6.1
		Foster Care	4,563	6,376	7,511	5,487	5,254	-17.6	15.1
		Median Other DSHS	2,407	2,642	2,524	2,537	2,336	-11.6	-2.9
		Median Community Res.	-----	10,626	10,753	10,775	9,764	-8.1	-----

Note: Values do not include Medicaid Personal Care add ons. These are state contributions only.

Note: Dollars for ICF/MR programs do not include IMR tax.

Note: Supportive Living includes alternative living, tenant support, and intensive tenant support. SOLA is an intensive tenant support program only.

Note: The value for supportive living is missing for SFY 1990 because the data for Region 4 were tracked through the county rather than through SSPS in that year.

Note: The value for adult family homes has been removed for SFY 1990 because this service was authorized differently in SSPS after this year.

Note: % change is based on both 4 year and 5 year time interval in this table. Because of unusal data points for several programs in SFY 1990, the four year estimate of change may be more accurate for planning purposes than the five year estimate.

- Median expenditures per person for community residential programs have remained fairly stable over the past four years, dropping slightly in SFY 1994.

- Among DDD provided programs, median expenditures per person increased more strongly in non-facility based programs than in facility based programs, and median expenditures per person for the SOLA program have generally been declining over the 4-year span, with expenditures per person in SFY 1994 being 20% lower than they were in SFY 1991.

- Trends in median expenditures per person in residential settings provided through other DSHS divisions have varied, depending on the program: increasing for nursing homes; remaining fairly stable for congregate care facilities; dropping for foster care in recent years; and dropping more sharply for adult family homes (primarily between SFY 1991 and SFY 1992), reflecting increased usage of Medicaid Personal Care (see Tables 4-11 and 4-12).

- SOLA, ICF/MRs, and nursing homes are the most expensive community residential programs on a per person basis, while housing in adult family homes costs the State very little. However, much of the difference between residential programs is due to different service levels.

Foster Care

Two forms of foster care are available to children: regular foster care and group treatment foster care. The following analyses explore expenditures for children enrolled in DDD and living in foster care. These services are financed by DCFS.

Table 4-4a: Expenditures for Foster Care (in thousands)

Foster Care		Fiscal Year					5 Year % Change
		1990	1991	1992	1993	1994	
Regular Foster Care	$	3,982	6,099	7,932	8,691	7,982	▨
	%	81.5	79.7	79.7	71.8	65.9	100.5
Group/Treatment Foster Care	$	905	1,558	2,022	3,420	4,125	▨
	%	18.5	20.3	20.3	28.2	34.1	355.8
Total Foster Care	$	4,887	7,657	9,954	12,111	12,107	147.7

- Expenditures for regular foster care increased to a high of $8.7 million before declining to $8 million in SFY 1994, while group and treatment foster care continued to increase by more than 20% each year -- from less than $1 million in SFY 1990 to over $4 million in SFY 1994.

- Expenditures for group and treatment foster care now (SFY 1994) account for more than one-third of total foster care expenditures for children also enrolled in DDD (up from less than 19% in SFY 1990).

Table 4-4b: Median Expenditures per Person for Foster Care (in dollars)

Foster Care	Fiscal Year					5 Year % Change
	1990	1991	1992	1993	1994	
Regular	4,062	5,952	6,932	4,691	4,440	9.3
Group/Treatment	19,129	15,457	19,488	19,855	21,713	13.5
Total Foster Care	4,563	6,376	7,511	5,487	5,254	15.1

- The reduction during recent years in median expenditures per child in foster care was primarily influenced by regular foster care, which increased from $4 million in SFY 1990 to $7 million in SFY 1992, reduced by 32% in SFY 1993, and maintained this lower level in SFY 1994.

- Median expenditures per child in group and treatment foster care increased in every year, except for a dip in SFY 1991. Group and treatment foster care median expenditures per child are approximately five times as high as for regular foster care.

EMPLOYMENT AND DAY PROGRAMS

Table 4-5a: Expenditures for Employment and Day Programs (in thousands)

Employment/Day Program		Fiscal Year 1990	1991	1992	1993	1994	5 Year % Change
Child Development	$	2,388	2,392	2,493	3,045	2,570	
	%	14.1	13.2	12.1	10.9	10.0	7.6
Individual Supported Employment	$	2,920	3,886	4,879	8,593	7,548	
	%	17.3	21.4	23.6	30.7	29.4	158.5
Group Supported Employment	$	4,049	3,759	3,944	4,738	4,572	
	%	23.9	20.7	19.1	16.9	17.8	12.9
Special Industries	$	5,960	5,754	6,567	7,459	6,758	
	%	35.2	31.7	31.8	26.6	26.3	13.4
Community Access	$	1,601	2,363	2,762	4,161	4,206	
	%	9.5	13.0	13.4	14.9	16.4	162.7
Total Employ/Day Prgm	$	16,918	18,154	20,645	27,996	25,654	51.6

Note: Information on total expenditures for each employment and day program type were obtained through FRS, and thus were available in every year

- Expenditures for individual supported employment have increased by 156% over the five-year span, and community access expenditures have increased by 163% (the largest increases in expenditures for these programs, more than 50% increase, occurred between SFY 1992 and SFY 1993; community access programs also experienced a 48% increase between SFY 1990 and SFY 1991), while child development programs, group supported employment and special industries expenditures have remained relatively stable.

- All employment and day programs, except for community access, experienced decreases in expenditures during SFY 1994, as compared with SFY 1993.

- In SFY 1994, the majority of expenditures for employment and day programs were for employment programs (over 73%), with the largest expenditure being for individual supported employment. In SFY 1990, the majority of expenditures for employment programs were for special industries. This reflects a change in the division's values toward individual employment situations over sheltered settings.

Table 4-5b Median Expenditures per Person for Employment and Day Programs (in dollars)[3]

	Fiscal Year					5 Year %
Employment & Day Programs	**1990**	**1991**	**1992**	**1993**	**1994**	**Change**
Child Development	-----	-----	-----	764	722	-----
Individual Supported Employment	879	1,383	1,499	3,405	3,487	296.7
Group Supported Employment	3,744	3,563	3,659	4,180	3,752	0.2
Special Industries	2,866	3,776	3,877	3,503	2,991	4.4
Community Access	1,934	2,965	2,561	3,237	2,890	49.4
Median Employment & Day Programs	-----	-----	-----	3,055	2,730	-----

Note: Expenditures for children receiving child development programs were not available in the data source prior to SFY 1993

Therefore, totals could not be computed for these years

- Median expenditures per person for individual supported employment increased strongly (from $879 per person in SFY 1990 to $3,487 per person in SFY 1994) and increased for special industries until SFY 1992 before declining. Median expenditures per person varied from year to year for other programs.

- Currently (SFY 1994), median expenditures per person for each type of employment program and community access are similar, and median expenditures per person for child development programs are much lower. Group supported employment is currently the most expensive form of employment and day program on a per person basis.

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[3] The values for median dollars for individual supported employment appeared low to DDD staff for SFY 1990 through SFY 1992. This pattern of strong increase was less marked in the means than in the medians: $2,492 (SFY 1990), $3,049 (SFY 1991), $2,991 (SFY 1992), $3,850 (SFY 1993), $3,863 (SFY 1994). Because of numerous factors and their interactions that could explain this pattern (e.g., start up and expansion of programs, additional funds available in recent years for transitions from high school to the adult world, and multiple sources for the data), these values should be considered tenous for accurate planning purposes.

Table 4-6a: Expenditures for Services Provided by Division of Vocational Rehabilitation (in thousands)

		Fiscal Year					5 Year %
DVR Services		1990	1991	1992	1993	1994	Change
Case Management	$	866	917	1,303	1,573	1,866	
	%	36.3	44.4	49.4	42.7	36.0	115.5
Vocational Assessment & Work Skill Building	$	88	120	149	196	393	
	%	3.7	5.8	5.7	5.3	7.6	346.6
Medical or Psych. Treatment	$	113	125	164	232	247	
	%	4.7	6.1	6.2	6.3	4.8	118.6
Education, Training & Supplies	$	1,071	719	786	1,305	1,964	
	%	44.9	34.8	29.8	35.4	37.9	83.4
Personal Support Services	$	75	60	33	36	53	
	%	3.1	2.9	1.3	1.0	1.0	-29.3
Placement Support Services	$	172	123	202	344	654	
	%	7.2	6.0	7.7	9.3	12.6	280.2
Total DVR $ for persons in DDD	$	2,385	2,064	2,637	3,686	5,177	117.1

Note: The total includes a small amount for other DVR services. These were never more than $1,000 in any fiscal year.

- Expenditures for all DVR services provided to persons also enrolled in DDD increased from $2.4 million in SFY 1990 to $5.2 million in SFY 1994.

- More dollars are being spent for all services provided to persons on the DDD caseload in recent years as compared with earlier in the five-year span, with the exception of personal support services and education, training, and supplies, which varied from year to year.

- Vocational assessment and work skill building expenditures have grown the fastest over the past five years, by 347%.

- The largest expenditures are for case management (36%) and education, training and supplies (38%), each approaching $2 million in SFY 1994.

Table 4-6b: Median Expenditures per Person for Services Provided by the Division of Vocational Rehabilitation (in dollars)

DVR Services	Fiscal Year 1990	1991	1992	1993	1994	5 Year % Change
Case Management	712	716	837	1,021	1,021	43.4
Vocational Assessment	475	500	523	570	625	31.6
Medical or Psych. Treatment	206	262	235	235	238	15.5
Education, Training & Supplies	1,762	1,528	1,540	1,860	1,960	11.2
Personal Support	66	58	60	59	70	6.1
Placement Support	400	480	518	550	694	73.5
Median DVR $ for persons in DDD	1,203	1,219	1,446	1,879	2,203	83.1

- Generally, median expenditures per person have increased for all services provided by DVR; although, median expenditures per person for personal support varied from year to year. Median expenditures per person for medical and psychological treatment in SFY 1991, and for education, training, and supplies in SFY 1990, were higher than expected, based on the levels and trends for other years.

- The greatest increase in median expenditures per person occurred for placement support services, with expenditures per person for case management and vocational services also increasing moderately.

- The most expensive services per person provided through DVR to individuals on the DDD caseload are case management and education, training, and supplies at $1000 and $2000 per person per year, respectively.

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Table 4-7a: Expenditures for Services Provided by the Division of Income Assistance (SFY 1991-1992, in thousands)[4]

Service		Average
AFDC/FIP	$	1,631
	%	27.7
SSI -- State Supplement	$	1,624
	%	30.8
GAU	$	397
	%	6.7
Food Stamps	$	1,817
	%	30.8
Other DIA Services	$	425
	%	7.2
Total DIA $ for persons in DDD	$	5,894

Note: Values in table are for state share only

- Food stamps, AFDC/FIP, and SSI -- State Supplement are the largest DIA expenses for families of persons on the DDD caseload.

- Less than one million is spent per year by DIA for other services provided to families of persons on the DDD caseload.

Table 4-7b: Median Expenditures per Family for Services Provided by the Division of Income Assistance (in dollars)

Service	Median
AFDC/FIP	1,579
SSI -- State Supplement	138
GAU	1,166
Food Stamps	551
Other DIA Services	139
Median DIA $ for persons in DDD	319

Note: Values in table are for state share only.

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[4] A total listing of DIA expenditures for persons on the DDD caseload was only available through the Needs Assessment data bases, which only covers state fiscal years 1990 to 1992. Since the data are most complete in this data base for SFY 1991 and 1992, an average of the numbers provided through this data base was used to estimate the expenditures for persons receiving services through DIA.

- The average family receiving AFDC or FIP with a member enrolled in DDD gets $1,579 of state funds per year. Families receiving GAU also receive over $1,000 per year.

- State funds contribute little per year to other programs on a per-family basis.

MEDICAL ASSISTANCE ADMINISTRATION

Table 4-8a: Expenditures for Services Provided by the Medical Assistance Administration (SFY 1991-1992, in thousands)[4]

	Service		Average
Medicaid	Categorically Needy	$	36,986
		%	99.1
	Medically Needy	$	324
		%	0.9
	Total Medicaid	$	37,311
		%	95.6
Other MAA	GAU/ADATSA	$	78
		%	0.2
	Others Receiving Medical Assistance	$	1,646
		%	4.2
Total	MAA $ for Persons in DDD	$	39,034

- Most (96%) of the state dollars spent by the Medical Assistance Administration on persons enrolled in DDD are received by individuals on Medicaid, most of whom are classified as categorically needy (99%).

- Others receiving medical assistance is the only category of persons enrolled in DDD for which over $1.6 million is spent per year by MAA (4% of total MAA expenditure for persons in DDD).

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[4] A total listing of MAA expenditures for persons on the DDD caseload was only available through the Needs Assessment data bases, which only covers state fiscal years 1990 to 1992. Since the data are most complete in this data base for SFY 1991 and 1992, an average of the numbers provided through this data base was used to estimate the expenditures for persons receiving services through MAA.

Table 4-8b: Median Expenditures per Person for Services Provided by the Medical Assistance Administration (in dollars)

Service	Median
Categorically Needy	738
Medically Needy	396
Median Medicaid	740
GAU/ADATSA	221
Others Receiving Medical	361
Median MAA $ for persons in DDD	371

- Overall, the state pays very little per person, on average, for medical services. Individuals typically receive less than $400 per year for medical costs from state funds.

- The State contributes the largest number of dollars, on a per person basis, to Medicaid programs, with persons classified as categorically needy receiving $738 per year for medical costs.

FAMILY SUPPORT SERVICES

Table 4-9a: Expenditures for Family Support Services (in thousands)

				Fiscal Year			5 Year % Change
Family Support Service		**1990**	**1991**	**1992**	**1993**	**1994**	
Respite	$	2,526	2,978	3,085	3,187	3,398	
	%	70.0	64.2	61.2	64.4	62.5	34.5
Attendant Care	$	781	1,024	1,157	959	864	
	%	21.6	22.1	22.9	19.4	15.9	10.6
Transportation	$	40	62	69	50	42	
	%	1.1	1.3	1.4	1.0	0.8	5.0
Professional Services	$	260	568	720	659	702	
	%	7.2	12.3	14.3	13.3	12.9	170.0
Other Family Support	$	4	4	11	97	428	
	%	0.1	0.1	0.2	2.0	7.9	10,600.0
Total Family Support	$	3,611	4,636	5,042	4,952	5,434	50.5

- Expenditures for other family support are increasing rapidly. This is due mainly to a change in the rules to allow an increase in payments for specialized aids or equipment deemed necessary to meet the individual's needs (see Table 3-8 for further details).

- Expenditures for professional services paid through family support funding have increased strongly as well, with the major increase occurring between SFY 1990 and SFY 1992.

- A slightly lower amount was spent on attendant care and transportation services in this biennium as compared to the previous biennium. Presently (SFY 1994) expenditures are similar, in terms of total dollars, to what they were five years ago.

- Most dollars spent for family support services are for respite care.

Table 4-9b: Median Expenditures per Person for Family Support Services (in dollars)

Family Support Services	Fiscal Year 1990	1991	1992	1993	1994	5 Year % Change
Respite	824	1,087	1,399	1,338	1,533	86.0
Attendant Care	1,679	1,882	2,382	2,263	1,764	5.1
Transportation	141	129	189	204	168	19.1
Professional Services	630	900	1,080	871	780	23.8
Other Family Support	272	35	129	300	567	108.5
Median Family Support	929	1,287	1,680	1,567	1,763	89.8

- Median expenditures per person for respite care increased over the five-year span (though being slightly higher than expected in SFY 1992), and expenditures per person for attendant care and for professional services increased until SFY 1992 before declining, while expenditures per person for other services were variable from year to year.

- Median expenditures per person for other family support services were particularly variable, from a low of $35 per person in SFY 1991 to a high of $567 per person in SFY 1994.

OTHER COMMUNITY SERVICES

Table 4-10a: Expenditures for Other Community Services (in thousands)

			Fiscal Year					5 Year %
	Other Community Services		**1990**	**1991**	**1992**	**1993**	**1994**	**Change**
DDD Provided	Attendant Care	$	-----	3,150	3,452	3,772	4,218	
		%	-----	49.0	48.5	53.1	54.7	-----
	Transportation	$	134	376	386	328	350	
		%	4.3	5.8	5.4	4.6	4.5	161.2
	Professional Services	$	598	856	953	961	1,113	
		%	19.2	13.3	13.4	13.5	14.4	86.1
	Supplemental Community Support	$	2,378	2,053	2,327	2,039	2,035	
		%	76.5	31.9	32.7	28.7	26.4	-14.4
	Total Other Comm. Service	$	3,110	6,435	7,118	7,100	7,716	148.1
Other DSHS	Child Care	$	542	823	1,020	1,762	1,728	218.8
	Personal Care Assist. Adults	$	5,440	7,881	9,502	12,353	14,145	160.0
	Other AASA/HCS	$	75	269	313	-----	-----	-----
	Other DCFS	$	471	727	1,321	-----	-----	-----

Note: Expenditures for persons receiving attendant care were not separated from supplemental community support in the data source for SFY 1990.

Note: Data on expenditures for persons receiving other services through AASA /HCS and DCFS were not available for SFY 1993 and SFY 1994.

Note: Personal care assistance for adults includes Medicaid, Chore, and COPES.

- Expenditures for transportation services increased from $134,000 in SFY 1990 to $376,000 in SFY 1991, and have remained at this higher level in recent years. Expenditures for professional services, paid through other community services funding, have also increased strongly -- by 86% over SFY 1990.

- The largest DDD expense through other community services funding is attendant care (over $4 million), while transportation expenditures are relatively small ($350,000).

- Expenditures for child care more than tripled, and expenditures for personal care assistance more than doubled between SFY 1990 and 1994 -- from $542,000 to $1.7 million for child care, and from $5.4 million to $14.1 million for personal care assistance.

- More dollars were spent for other services provided through AASA/HCS and DCFS each year (SFY 1990-1992).

Table 4-10b: Median Expenditures per Person for Other Community Services (in dollars)

			Fiscal Year				5 Year %
Other Community Services		1990	1991	1992	1993	1994	Change
DDD	Attendant Care	-----	5,293	5,760	5,831	6,016	-----
Provided	Transportation	86	145	176	195	185	115.1
	Professional Services	300	500	500	502	720	140.0
	Supplemental	1,946	660	690	600	482	-75.2
	Median DDD Community Svcs	300	450	440	478	510	70.0
Other DSHS	Child Care	759	1,084	1,295	1,429	1,384	82.3
	Personal Care Assist. Adults	1,946	2,701	2,987	3,768	4,113	111.4
	Other AASA/HCS	174	157	166	-----	-----	-----
	Other DCFS	273	137	150	-----	-----	-----

Note: Expenditures for persons receiving attendant care were not separated from supplemental community support in the data source for SFY 1990.

Note: Data on expenditures for persons receiving other services through AASA/HCS and DCFS were not available for SFY 1993 and SFY 1994.

Note: Personal care assistance for adults includes Medicaid, Chore, and COPES.

- Median expenditures per person for supplemental community support declined sharply in SFY 1991 and again in SFY 1994; whereas, median expenditures per person for professional services showed the opposite pattern, increasing in SFY 1991 and again in SFY 1994.

- Median expenditures per person increased over the time span for attendant care and transportation (although median expenditures per person for transportation decreased slightly in SFY 1994 as compared with SFY 1993).

- Median expenditures per person for other community services provided through other DSHS divisions also increased strongly over the five-year span; although median expenditures per person for child care decreased slightly in SFY 1994 as compared with the previous year, and median expenditures for other services offered through AASA/HCS and DCFS were higher in SFY 1990 than they were in SFY 1991 and 1992.

Since a large number of individuals on the DDD caseload receive child care services and personal care services through other divisions, the following analyses explore expenditures for these services in more detail.

Table 4-11a: Expenditures for Child Care (in thousands)

		Fiscal Year					5 Year %
Child Care		**1990**	**1991**	**1992**	**1993**	**1994**	**Change**
Employment & Training	$	92	173	255	456	523	
	%	17.0	21.0	25.0	25.9	30.3	468.5
Therapeutic	$	261	392	391	635	537	
	%	48.2	47.7	38.3	36.0	31.1	105.7
Child Protective Services	$	189	257	374	671	667	
	%	34.9	31.3	36.7	38.1	38.6	252.9
Income Assistance	$	83	96	133	-----	-----	
	%	-----	-----	-----	-----	-----	-----
Other Child Care	$	8	15	34	-----	-----	
	%	-----	-----	-----	-----	-----	-----
Total Child Care	$	542	822	1,020	1,762	1,727	218.6

Note: Expenditures for children receiving income assistance child care and other child care were not available for SFY 1993 and 1994. Because of this, dollars for these services are not included in the total for any year.

- Total child care expenditures increased from $542,000 in SFY 1990 to $1.7 million in SFY 1994, with expenditures increasing strongly for every form of child care.

- Expenditures were highest for therapeutic child care in SFY 1990, but now (SFY 1994) expenditures are similar for employment and training child care, therapeutic child care and CPS child care.

Table 4-11b: Median Expenditures per Person for Child Care (in dollars)

	Fiscal Year					5 Year %
Child Care	**1990**	**1991**	**1992**	**1993**	**1994**	**Change**
Employment & Training	873	1,044	1,138	1,277	1,120	28.3
Therapeutic	3,569	4,144	4,482	4,080	3,400	-4.7
Child Protective Services	360	594	684	837	745	106.9
Income Assistance	413	480	453	-----	-----	-----
Other Child Care	614	938	846	-----	-----	-----
Median Child Care	759	1,084	1,295	1,429	1,384	82.3

Note: Expenditures for children receiving income assistance child care and other child care were not available for SFY 1993 and SFY 1994. Because of this, dollars for these services are not included in the total for any year.

- Median expenditures per child for all forms of child care decreased in SFY 1994 as compared with SFY 1993. However, patterns of increase over the entire five-year span varied depending on the type of child care.

- Median expenditures per child for CPS child care more than doubled, and median expenditures per child for employment and training child care also increased moderately over the five-year span.

- Median expenditures per child peaked for therapeutic child care in SFY 1992 before declining, and median expenditures for income assistance and other forms of child care were higher in SFY 1991 than in other years.

Personal Care Assistance

Table 4-12a: Expenditures for Personal Care Assistance (in thousands)

			Fiscal Year					5 Year %
	Personal Care		1990	1991	1992	1993	1994	Change
Adult Medicaid	Home	$	1,625	2,776	3,785	5,266	7,833	
	% Medicaid Adults	%	64.0	56.9	61.4	64.1	68.2	382.0
	Congregate Care Facility	$	114	281	317	379	441	
	% Medicaid Adults	%	4.5	5.8	5.1	4.6	3.8	286.8
	Adult Family Home	$	799	1,805	2,044	2,543	3,186	
	% Medicaid Adults	%	31.4	37.0	33.1	30.9	27.7	298.7
	Total Medicaid Adults	$	2,541	4,875	6,169	8,220	11,484	
	% Personal Care	%	46.7	61.9	64.9	67.3	81.2	351.9
Chore	Contracted	$	2,280	2,330	2,459	2,877	1,584	
		%	100.0	95.5	94.9	92.1	86.0	-30.5
	State Provided	$	-----	110	132	247	257	
		%	-----	4.5	5.1	7.9	14.0	-----
	Total Chore	$	2,280	2,440	2,591	3,124	1,841	
	% Personal Care	%	41.9	31.0	27.3	25.6	13.0	-19.3
COPES	COPES	$	617	565	740	863	819	
	% Personal Care	%	11.3	7.2	7.8	7.1	5.8	32.7
	Total Personal Care Asst.	$	5,438	7,880	9,500	12,207	14,144	160.1

Note: Expenditures for State provided Chore services were not available for SFY 1990 in the data source.

Note: Total expenditures for Medicaid personal care include expenditures for persons receiving funding during IMR transfers.

Note: Medicaid totals and total personal care assistance do not include Medicaid Personal Care for children. See Table 4-1a for Medicaid Personal Care expenditures for children.

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- Total personal care assistance dollars have increased by 160% since SFY 1990 -- from $5.4 million to over $14 million.

- Most personal care dollars are from Medicaid, and this percentage almost doubled over the five-year span -- from 47% to 81%. Expenditures for all forms of Medicaid Personal Care are increasing strongly -- close to quadrupling or higher for every form of adult Medicaid Personal Care.

- Most Chore services are contracted rather than state provided. Total Chore service dollars decreased 45% in SFY 1994 as compared with the previous year, to a level even lower than SFY 1990. Although, expenditures for state provided Chore services increased every year over the past four years.

- Spending for COPES varied from year to year, but was higher in recent years than earlier in the five-year span.

Table 4-12b: Median Expenditures per Person for Personal Care Assistance (in dollars)

		Fiscal Year					5 Year %
	Personal Care	1990	1991	1992	1993	1994	Change
Adult Medicaid	Home	650	2,204	2,479	3,573	4,697	622.6
	Congregate Care Facility	386	910	1,182	1,428	1,578	308.8
	Adult Family Home	1,166	2,599	2,892	3,104	3,433	194.4
	Median Adult Medicaid	1,467	2,204	2,479	3,214	3,834	161.3
Chore	Contracted	2,853	5,451	5,771	5,807	4,004	40.3
	State Provided	-----	1,610	1,885	2,461	2,709	-----
	Median Chore	2,853	3,836	4,209	4,908	3,768	32.1
	COPES	5,187	7,545	9,270	11,810	10,234	97.3
	Median Personal Care Asst.	1,946	2,701	2,987	3,768	4,113	111.4

Note: Expenditures for State provided Chore services were not available for SFY 1990 in the data source.

Note: Total expenditures for Medicaid personal care include expenditures for persons receiving funding during IMR transfers

Note: Median Medicaid totals and median personal care assistance do not include Medicaid Personal Care for children. See Table 4-1b for median Mediad Personal Care expenditures for children

- More dollars are being spent per person on personal care assistance every year; although, median expenditures per person were lower in SFY 1994 for contracted Chore and for COPES, as compared with the previous year.

- Median expenditures per person for Medicaid Personal Care have increased particularly strongly, with over four times as much being spent per person living in congregate care facilities and over seven times as much being spent for persons living at home. Median expenditures per person for Medicaid Personal Care for individuals living in adult family homes have also more than doubled in just five years.

- Median expenditures per person for personal care assistance services are greatest through the COPES program, and lowest through Medicaid Personal Care for individuals living in congregate care facilities.

CHAPTER 5

STAFFING FOR RESIDENTIAL PROGRAMS

The following analyses explore staffing levels for residential programs. Staffing levels for other types of services were not readily available. Appendices E through I present staffing for each residential program type by region. Staffing of regional field service offices is presented in Appendix J.

The following analyses are meant as a presentation of patterns and trends within a specific program type rather than a comparison across programs. A comparison of staffing levels across programs is indicative of differences in the services offered. Due to the large variety of variables affecting where people live and the services offered, this analysis cannot address the efficiency or quality of these programs. Programs listed in the tables of this chapter are ordered by level of service within a specific program type (i.e., state provided, contracted facility based, contracted non-facility based).

There are differences in the nature of data presented for DDD provided facilities and for contracted facilities which further hinder cross-program comparisons. Staffing data for DDD facilities were provided in the form of total person-months for a fiscal year. These numbers were divided by 12 to calculate an average monthly number of FTEs for these programs. Staffing data for contracted programs were provided in the form of number of FTEs in the contract for one particular month. The month of July was provided since this is the month when the data base is thoroughly updated. DDD representatives state that the number of staff in the contract for each month varies little from month to month. An implication of this difference in data formats is that staffing counts for DDD facilities include all paid hours worked, while staffing counts for other programs include only those hours originally established in the contract, and therefore exclude any overtime hours worked. Therefore, comparing hours provided in DDD services to hours provided in contracted services is tenuous at best.

Additionally, staffing data for DDD facilities differs from data for the contracted facilities in that the data for DDD facilities were provided as a sum of all staff employed at the facility, including direct care staff, administration, and support personnel; whereas, data for the contracted facilities were provided for direct care staff only. For these reasons, comparing counts between DDD facilities and contracted facilities is inappropriate. Since all staff are included in the counts for DDD facilities, DDD programs appear to have much higher staffing than comparable contracted facilities.

STAFFING FOR RESIDENTIAL PROGRAMS

Table 5-1a: FTEs for DDD Provided Residential Programs

	Fiscal Year					5 Year %
Residence Type	**1990**	**1991**	**1992**	**1993**	**1994**	**Change**
SOLA	27	161	208	228	217	708.6
RHC	3425	3633	3746	3562	3309	-3.4

Table 5-1b: FTEs for Contracted Residential Programs

		July 1 Contract					5 Year %
	Residence Type	**1990**	**1991**	**1992**	**1993**	**1994**	**Change**
Facility Based	Group Home	552	582	518	511	499	-9.7
	ICF/MR	614	489	504	444	411	-33.0
Non-Facility	Supportive Living	0	50	49	70	109	-----
	Tenant Support	85	80	76	62	49	-42.7
	Intensive Tenant Support	777	1657	1734	1649	1993	156.5

Note: Staffing for DDD provided residential services includes all staff. Staffing for contracted residential services includes only direct care staff.

- Most of the staff serving individuals in residential programs are working in RHCs and intensive tenant support programs.

- Intensive tenant support, supportive living, and SOLA programs had more staff in SFY 1994 than during SFY 1990; all others had less.

- SOLA programs decreased staffing in SFY 1994 -- down 4.5% from SFY 1993. RHCs increased staffing till SFY 1992, then declined. Staffing in SFY 1994 was down 11.7% from its peak.

- Contracted programs varied in their staffing trends. The number of direct care staff in group homes decreased after SFY 1991; staffing at ICF/MRs decreased over the five-year span, though being slightly higher in SFY 1992 than in SFY 1991; staffing for supportive living programs increased in SFY 1993 and SFY 1994; staffing at tenant support programs decreased every year; and staffing for intensive tenant support programs increased from 777 in SFY 1990 to 1,993 by SFY 1994, with an increase of 880 FTEs in SFY 1991, varying between SFY 1991 and 1993, and increasing again by 344 FTEs in SFY 1994.

STAFFING PER PERSON DAY

Staff hours per person day were provided in the data set for contracted programs. Similar values were computed using staffing levels for DDD facilities (i.e., RHCs and SOLA) and average daily person counts for these programs. For DDD facilities, the number of FTEs was multiplied by 40 (hours per week), divided by 7 (days per week), then divided by the average daily person count to get an estimate of the number of staff hours per person day. The resulting number is a similar unit to that provided for contracted programs; however, there are some differences. Individuals and staff for DDD facilities are counts of actual persons; whereas, individuals and staff for contracted programs are contracted staffing and contracted capacity. In contracted programs, staff overtime is not included, and person counts are total capacity rather than actual number of individuals in residence. At times there may have been unfilled slots. Also, staffing levels at DDD facilities include all staff, while staffing levels for contracted programs include direct care staff only.

Table 5-2a: Staff Hours Per Person Day for DDD Provided Residential Services

	Fiscal Year					5 Year %
Residence Type	**1990**	**1991**	**1992**	**1993**	**1994**	**Change**
SOLA	22.0	20.4	17.8	16.5	13.7	-37.7
RHC	11.1	12.9	14.0	13.8	13.4	20.7

- SOLA programs decreased staffing per person in residence every year, currently (SFY 1994) operating with 38% fewer staff hours per person than in SFY 1990.

- Staffing per person in residence increased at RHCs till SFY 1992, but declined slightly in SFY 1993 and 1994.

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Table 5-2b: Staff Hours Per Person Day for Contracted Community Residential Services

		July 1 contract					5 Year %
	Residence Type	1990	1991	1992	1993	1994	Change
Facility Based	Group Home	3.7	4.0	4.1	4.1	4.3	17.5
	ICF/MR	5.8	6.4	7.3	7.4	7.8	34.5
Non-Facility	Supportive Living	-----	1.3	1.3	1.2	1.1	-----
	Tenant Support	1.5	1.5	1.5	1.3	1.8	20.0
	Intensive Tenant Support	7.2	8.8	8.8	8.4	8.5	18.1

Note Staffing for DDD provided residential services includes all staff. Staffing for contracted residential services includes only direct care staff

- Group homes and ICF/MRs appear to have experienced slight increases in staffing levels. This is an artifact of the closure of primarily the larger facilities, resulting in a higher proportion of smaller facilities. A larger staff per person ratio is required to run a small facility than to run a larger facility.

- Intensive tenant support programs increased staffing levels per person only until SFY 1993, reflecting a budget cut in the SFY 1993 legislative session.

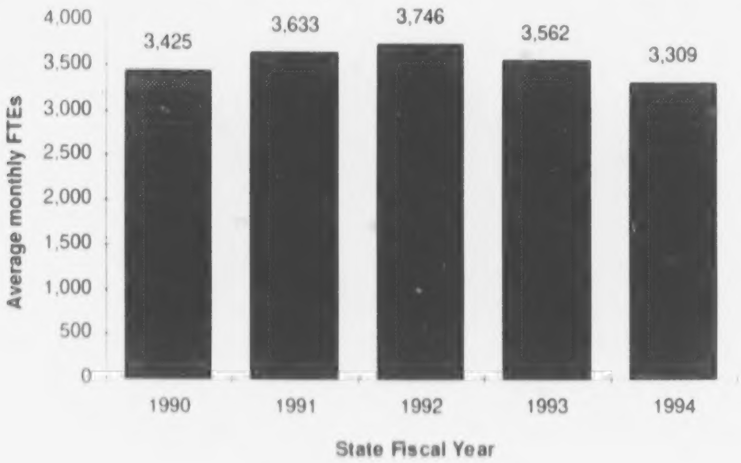
- Staffing per person in tenant support programs remained stable until SFY 1993, and staffing per person in Supportive Living programs decreased in the most recent biennium over the previous biennium.

- During downsizing of RHCs, people with more significant needs were placed into community residential settings. This, in part, helps explain the mild increase in staffing levels for most contracted community residential programs during SFY 1994. Supportive Living was the only contracted community residential program to experience a decrease in SFY 1994, as compared with SFY 1993.

STAFFING FOR RHCs

The following analyses explore staffing levels for RHCs in more detail since reduction of RHCs and their staffing has been a major goal of the Division. The number of FTEs employed at all RHCs is shown in Figure 5-1 by state fiscal year; counts include all direct care staff, administration, and support personnel. The impact of the closure of Interlake School on RHC staffing levels is discussed in Appendix F.

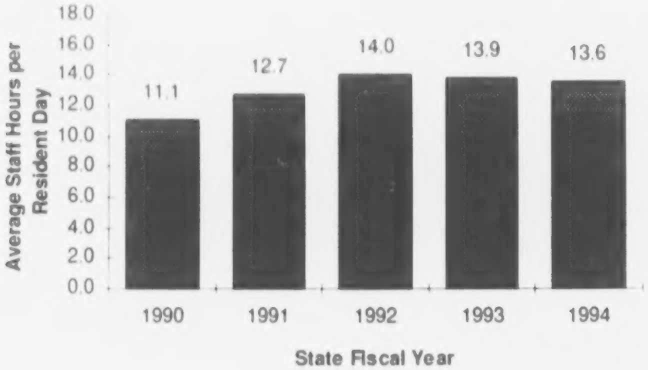
Figure 5-1: Statewide RHC Staffing



- Staffing for all RHCs combined increased to a high of 3,746 FTEs in SFY 1992 and then declined to 3,309 in SFY 1994, a level 3% lower than in SFY 1990.

STAFF HOURS PER PERSON DAY FOR RHCs

Figure 5-2: Average Staff Hours per Person Day at RHCs



- Staff hours per person day increased from 11.1 hours per person in residence in SFY 1990 to 14.0 in SFY 1992, then dropped off in SFY 1993 and SFY 1994 to 13.6 hours per person day.

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APPENDICES

APPENDIX A

RECORD UNDUPLICATION

In order to accurately count persons on the DDD caseload and measure their service usage, information from all data sources were unduplicated at the person level against the DDD Common Client Database (CCDB). The data sources do not always store names using the same conventions. These inconsistent storage techniques hinder unduplication methods, thus all names were standardized. For example:

- All special characters (e.g., -,",+,\,&, etc.) were converted to spaces;
- All name suffixes, such as 'JR','SR','II','III','IV', were dropped;
- All embedded spaces were compressed. For example, O MALLEY became OMALLEY and MC CALL became MCCALL

An individual could appear more than once in a single data source with slightly different identification data over the five years. In addition, the same person could conceivably appear in all of the data sources. So that one individual is not counted as more than one person, individuals were unduplicated against the CCDB using the following criteria:

1. If the Social Security Number and Date of Birth match,
   then assign the DDD serial number to that person.
   Otherwise;
2. If the Social Security Number, Last Name and First Initial match,
   then assign the DDD serial number to that person.
   Otherwise;
3. If the First Name, Last Name and Date of Birth match,
   then assign the DDD serial number to that person.

Two sources were processed with exceptions to the above criteria:

- **Medicaid Management Information System (MMIS)**: All DDD caseload member's serial numbers and "piccodes" (comprised of the first five letters of the last name, first and middle initial, and date of birth) were supplied to Medical Assistance Administration staff for matching against their caseload history file. They supplied a file of DDD serial numbers and the piccodes that were found in their database. These data were used to link MMIS data to persons on the DDD caseload.

- **Social Service Payment System (SSPS)**: Records for services authorized at DDD field offices are supposed to contain the individual's serial number. The serial number was extracted from these records and matched against the CCDB. If the serial number was found and either the name, Social Security Number, or date of birth matched, the serial number was assigned to that record. Otherwise, the data were processed using the above unduplication criteria.

There were a small number of DDD paid services from NADB (for SFY 1990 through 1992) and SSPS (for SFY 1993 and 1994) that could not be linked to the CCDB. The most probable cause for this is an individual's name being spelled differently in the two sources, in addition to having either a missing or incorrect date of birth or Social Security Number. In these cases a unique "serial number" was created for the individual. This may result in slightly higher than actual person counts for some services.

APPENDIX B

RESPITE CARE IN RHCs

Table B-1: Respite Care Stays in RHCs

		Fiscal Year										
		1990		1991		1992		1993		1994		5 Year %
Location		N	%	N	%	N	%	N	%	N	%	Change
Fircrest	Persons	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	-----
	Stays	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	-----
Interlake	Persons	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	-----
	Stays	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	-----
Lakeland	Persons	1	10.0	4	19.0	3	10.7	2	6.5	3	7.9	200.0
	Stays	1	9.1	36	55.4	40	43.0	28	32.9	28	23.9	2,700.0
FHMC	Persons	8	80.0	12	57.1	18	64.3	24	77.4	28	73.7	250.0
	Stays	8	72.7	24	36.9	45	48.4	51	60.0	73	62.4	812.5
Rainier	Persons	0	0.0	1	4.8	3	10.7	3	9.7	4	10.5	-----
	Stays	0	0.0	1	1.5	4	4.3	4	4.7	13	11.1	-----
Yakima	Persons	1	10.0	4	19.0	4	14.3	2	6.5	3	7.9	200.0
	Stays	2	18.2	4	6.2	4	4.3	2	2.4	3	2.6	50.0
Total RHC Respite	Persons	10		21		28		31		38		280.0
	Stays	11		65		93		85		117		963.6

Note Data was obtained from each facilities records Data for Interlake School was obtained from the CCDB since the facility is now closed

- The number of persons receiving respite care in RHCs nearly quadrupled, and the number of stays increased by 10 times over the five-year span.

- Many of the persons receiving respite care have more than one stay per year.

Table B-2: Length of Respite Care Stays by RHC Over the Entire Five-Year Span

	Length of Stay in Days			
RHC	**1-3**	**4-8**	**9-15**	**16+**
Fircrest	0	0	0	0
Interlake	0	0	0	0
Lakeland	117	9	2	5
FHMC	22	170	1	8
Rainier	7	4	0	11
Yakima	1	2	2	10
Total	147	185	5	34

Note Data was obtained from each facilities records. Data for Interlake School was obtained from the CCDB since the facility is now closed.

- Respite care stays in RHCs are generally rare, and most stays are at either Lakeland or FHMC, with the typical stay at FHMC (4-8 days) tending to last a few days longer than at Lakeland (1-3 days).

- A few stays occurred at Rainier and Yakima, and these stays were most commonly longer stays (16+ days).

APPENDIX C

EXPENDITURES FOR RHCs BY CENTER

Expenditures analyzed in this appendix include costs paid by the Division of Developmental Disabilities for the operation of Residential Habilitation Centers. Expenditures are total dollar amounts, as reported in FRS, for each fiscal year. Costs of services paid for by individuals or other agencies are not included. These dollar amounts are not adjusted for inflation and do not include IMR tax.

TOTAL EXPENDITURES FOR RHCs

Table C-1: Total Annual Expenditures for RHCs (in thousands, excludes IMR tax)

		Fiscal Year					**5 year % change**
RHC		***1990***	***1991***	***1992***	***1993***	***1994***	
Fircrest	$	36,116	40,220	45,677	45,019	42,694	
	% change		11.4	13.6	-1.4	-5.2	18.2
Interlake	$	14,180	16,134	15,864	14,270	11,514	
	% change		13.8	-1.7	-10.0	-19.3	-18.8
Lakeland	$	21,213	25,855	29,784	30,127	28,909	
	% change		21.9	15.2	1.2	-4.0	36.3
FHMC	$	3,837	4,318	5,109	5,342	5,372	
	% change		12.5	18.3	4.6	0.6	40.0
Rainier	$	35,851	42,630	44,059	44,668	44,152	
	% change		18.9	3.4	1.4	-1.2	23.2
Yakima	$	9,968	11,704	13,410	14,022	13,779	
	% change		17.4	14.6	4.6	-1.7	38.2
Total RHC	$	121,165	140,939	153,952	153,444	146,391	
	% change		16.3	9.2	-0.3	-4.6	20.8

- Total annual expenditures for all RHCs combined increased from $121 million in SFY 1990 to a high of $154 million in SFY 1992, then declined to $146 million

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by SFY 1994. Expenditures for SFY 1994 were 21% higher than during SFY 1990, but 5% lower than when expenditures peaked in SFY 1992. This is an underestimate of the actual cuts in expenditures because dollar amounts are not adjusted for inflation.

- Expenditures for Lakeland, FHMC, and Yakima are approximately 40% more than they were five years ago, as compared to approximately 20% more for Rainier and Fircrest.
- With the exception of FHMC where expenditures increased every year (the only facility that is not downsizing), expenditures for every other RHC declined between SFY 1993 and SFY 1994. Fircrest decreased expenditures in SFY 1993 as well, and Interlake decreased expenditures beginning in SFY 1992.

EXPENDITURES PER PERSON DAY FOR RHCs

Expenditures per person day were computed by dividing total expenditures by the average daily person count in a given fiscal year. This gives a rough estimate of the average cost per individual. Actual expenditures will vary from individual to individual, however.

Table C-2: Expenditures Per Person Per Day for RHCs

	Fiscal Year										
	1990		1991		1992		1993		1994		5 year %
RHC	$/day	$/year	$/day	$/year	$/day	$/year	$/day	$/year	$/day	$/year	change
Fircrest	205	74,883	248	90,544	297	108,522	311	113,398	305	111,386	48.7
Interlake	195	71,044	258	94,349	318	116,475	318	115,926	313	114,229	60.8
Lakeland	181	66,207	235	85,841	262	95,831	268	97,815	277	101,045	52.6
FHMC	195	71,194	220	80,407	259	94,966	270	98,378	272	99,305	39.5
Rainier	177	64,644	230	84,099	248	90,919	261	95,241	258	94,040	45.5
Yakima	184	67,038	231	84,205	285	104,200	303	110,759	316	115,211	71.9
Average	189	68,864	239	87,167	274	100,263	284	103,821	284	103,595	50.4

Note: Average row is a weighted average by facility size

- Average expenditure per day for a person residing in an RHC has increased by more than 50% over the five-year span. The increase occurred between SFY 1990 and SFY 1993, while expenditures remained stable in SFY 1994.
- Every center has increased expenditures per person since SFY 1990, although 3 of the six RHCs (Fircrest, Interlake, and Rainier) showed slight declines in expenditures per person in SFY 1994 as compared with SFY 1993.

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- Yakima Valley School experienced the highest increase in expenditures per person over the five-year span, spending $132 more per person day in SFY 1994 than in SFY 1990.

- The increase in expenditures per person at Interlake is difficult to evaluate due to the closure process. For instance, certain costs, such as building maintenance, overhead and closing costs, remain the same regardless of the number of individuals living there.

- Interlake and Yakima Valley School spent the most per person in SFY 1994 ($313 and $316 per person day, respectively), and Rainier School spent the least per person ($258 per person day).

APPENDIX D

EXPENDITURES FOR COMMUNITY SERVICES BY REGION

The following analyses explore costs paid by the Division of Developmental Disabilities for community programs. Expenditures are total dollar amounts, as reported in FRS, for each fiscal year. Costs of services paid for by individuals or other agencies are not included, and dollar amounts are not adjusted for inflation. These numbers and ratios are not comparable to the analyses for RHCs presented in Appendix C because most persons living in RHCs receive 24-hour intensive supervision and care; whereas, some persons living in the community require little assistance beyond occasional case management services. Many factors make the services received in RHCs more expensive than community based services. Furthermore, almost all living expenses for persons living in RHCs are paid for by the Division of Developmental Disabilities. Most people living in the community receive only a few hours of support services per month to a few hours per day and, therefore, expenditures for these services do not include living expenses. For many reasons, the following analyses should be considered separate and distinct from the previous analyses for RHCs.

TOTAL EXPENDITURES FOR COMMUNITY SERVICES

Table D-1: Total Annual Expenditures for Community Programs (in thousands)

Region		Fiscal Year					5 year % change
		1990	1991	1992	1993	1994	
Region 1	$	9,448	16,159	17,892	20,924	22,068	
	% change		71.0	10.7	16.9	5.5	133.6
Region 2	$	7,407	11,014	12,346	14,238	14,296	
	% change		48.7	12.1	15.3	0.4	93.0
Region 3	$	10,735	15,985	17,544	20,316	20,144	
	% change		48.9	9.8	15.8	-0.8	87.6
Region 4	$	29,147	41,509	45,117	54,816	53,406	
	% change		42.4	8.7	21.5	-2.6	83.2
Region 5	$	14,806	22,055	23,462	28,444	27,631	
	% change		49.0	6.4	21.2	-2.9	86.6
Region 6	$	13,108	18,955	21,239	25,133	23,985	
	% change		44.6	12.0	18.3	-4.6	83.0
Total	$	84,651	125,677	137,601	163,871	161,529	
	% change		48.5	9.5	19.1	-1.4	90.8

- Total annual expenditures for community programs increased from $85 million to $162 million over the past five years, although expenditures dropped slightly in SFY 1994 as compared with the $164 million spent in SFY 1993. Expenditures for community programs were 91% higher in SFY 1994 than SFY 1990; most of this increase was due to the 48% jump in expenditures between SFY 1990 and SFY 1991.

- Virtually all regions have shown similar increases in their total expenditures for community programs. All regions experienced strong increases in expenditures in SFY 1991, but Region 1 experienced a larger percentage increase in expenditures than other regions (71% vs. 42-49% in other regions).

- All but Regions 1 and 2 decreased expenditures in SFY 1994.

EXPENDITURES PER PERSON PER DAY FOR COMMUNITY PROGRAMS

The following analyses present average costs per person over all community programs; however, individual programs vary greatly in their cost per person. Information on the number of individuals receiving particular programs and financial breakdowns by program within region were not accessible at the time this report was written. Expenditures per person are also averages over all individuals on the DDD caseload who are living in the community. In actuality, expenditures per person vary greatly from individual to individual due to broad variability in the amount of service needed to support community living. Many individuals receive no services through DDD beyond occasional case management, and others receive 24-hour one-on-one care. Expenditures per person per day were computed by dividing total expenditures for community programs by the average daily person count for caseload members living in a particular region's administrative responsibility. Actual expenditures per person are probably somewhat higher than these estimates because several people who are eligible for DDD services receive no services through DDD other than case management (see Chapter 3).

Table D-2: Expenditures Per Person Per Day and Year in the Community

	Fiscal Year										
	1990		1991		1992		1993		1994		5 year %
Region	$/day	$/year	$/day	$/year	$/day	$/year	$/day	$/year	$/day	$/year	change
Region 1	16	5,781	24	8,869	24	8,671	24	8,883	23	8,427	45.8
Region 2	15	5,332	20	7,146	20	7,304	21	7,724	19	7,074	32.7
Region 3	14	5,067	19	7,110	20	7,267	21	7,780	20	7,398	46.0
Region 4	25	9,097	33	11,957	33	12,147	34	12,563	29	10,729	17.9
Region 5	16	5,914	23	8,226	23	8,288	26	9,354	24	8,582	45.1
Region 6	16	5,776	21	7,803	23	8,260	26	9,466	24	8,657	49.9
Average	18	6,453	24	8,854	25	9,003	27	9,714	24	8,812	36.6

Note: Average row is a weighted average by regional caseload size

- On average, the Division pays $24 per day per person for community based programs. This figure has remained fairly constant over the last four years, although it was slightly higher in SFY 1993 and 25% lower in SFY 1990.

- All regions experienced increases in expenditures per person until SFY 1994, when they all experienced slight declines as compared with SFY 1993. All regions experienced their largest increase in expenditures between SFY 1990 and SFY 1991, corresponding with the trend in total expenditures discussed above.

- Region 6 experienced the highest increase in expenditures per person over the five-year span in terms of actual dollars per person. They spent $8 more per caseload member in SFY 1994 than in SFY 1990 -- an increase of nearly 50% over five years.

- Regions vary slightly in the amount spent on community based services per individual. Region 4 spends more per person day on community based services than do any of the other regions ($29 per person per day), and Regions 2 and 3 spend less per person day ($19 and $20, respectively).

APPENDIX E

STAFFING FOR SOLAs

STAFFING FOR SOLAs

The numbers of FTEs employed in SOLA programs are shown in Table E-1 by state fiscal year and by region. The counts include all direct care staff, administration, and support personnel.

Table E-1: Staffing Levels for SOLAs by Region

	July 1 contract					5 Year %
Region	**1990**	**1991**	**1992**	**1993**	**1994**	**Change**
Region 1	5	37	47	45	44	791.7
Region 2	1	23	40	42	41	2,866.3
Region 3						-----
Region 4	15	70	90	109	102	578.1
Region 5	6	30	31	32	31	450.5
Region 6						-----
Statewide	27	161	208	228	217	708.6

- Regions 1, 4 and 5 have had SOLA programs since SFY 1990, and Region 2 had a few staff in SFY 1990 in preparation for the beginning of their SOLA program in SFY 1991. Regions 3 and 6 do not have SOLA programs.

- Staffing increased in SFY 1991 as SOLA programs expanded, and continued to increase until SFY 1993 in Region 1 and until SFY 1994 in other regions when the number of FTEs employed in SOLA programs declined, although the number of individuals living in SOLAs continues to increase (see Chapter 3).

STAFF HOURS PER PERSON DAY FOR SOLAs

Staff hours per person day for SOLAs were computed by dividing average monthly FTEs by average daily person counts for a given fiscal year, then multiplying by 40 (hours per week), and dividing by 7 (days per week). This provides a rough estimate of the number of hours of service provided per person, although service time varies from individual to individual based on need. The number of hours only includes regular hours plus paid overtime; unpaid exchange time and compensatory time were not included. The statewide numbers are weighted averages, based on program capacity within regions.

Table E-2: Staff Hours per Person Day in SOLA Programs by Region

	July 1 contract					5 Year %
Region	1990	1991	1992	1993	1994	Change
Region 1	28.2	23.7	20.8	17.1	14.8	-47.5
Region 2		33.1	20.7	15.9	14.6	-----
Region 3						-----
Region 4	17.2	16.7	15.2	15.9	12.7	-26.3
Region 5	31.7	21.6	19.6	18.5	14.5	-54.1
Region 6						-----
Statewide	22.0	20.4	17.8	16.5	13.7	-37.8

Note: Statewide row is a weighted average by regional program size.

- The number of staff hours per person day decreased in almost every year for every region as methods were found to make these programs more efficient.

- Regions used to vary widely in their number of staff hours per person day, although currently (SFY 1994) programs provide 13.7 hours per person day, on average. Region 4 provides slightly fewer hours per person day (12.7 hours in SFY 1994) than other regions (14.5 to 14.8 hours per person day).

APPENDIX F

STAFFING FOR RHCs

STAFFING FOR RHCs

Table F-1: Staffing Levels by RHC

	Fiscal Year					5 Year %
Center	1990	1991	1992	1993	1994	Change
Fircrest	1,031	1,029	1,127	1,048	963	-6.6
Interlake	393	399	377	311	253	-35.6
Lakeland	600	679	733	709	655	9.2
FHMC	108	109	120	119	122	12.8
Rainier	1,023	1,118	1,068	1,036	1,008	-1.4
Yakima	271	299	320	340	308	13.7
All RHCs	3,425	3,633	3,746	3,562	3,309	-3.4

- Almost all RHCs increased staffing then declined staffing over the five-year span, although the year in which staffing peaked varied from center to center.

- With respect to the individual RHCs, by the end of SFY 1994 staffing at Fircrest School declined 14.5% from its peak staffing, Lakeland declined 10.6%, Rainier declined 9.8%, and Yakima Valley declined 9.4%. FHMC showed no appreciable decline.

Table F-2 explores the closure of Interlake and its effects on the other centers by looking at staffing changes at each RHC for January through August 1994.

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Table F-2: RHC Staffing Levels, January to August 1994

	Calendar Year 1994							
Center	Jan	Feb	Mar	Apr	May	June	July	Aug
Fircrest	1,022	976	913	895	878	835	881	848
Interlake	266	263	246	240	222	154	67	5
Lakeland	656	632	608	612	632	638	704	672
FHMC	129	121	117	120	119	115	127	120
Rainier	1,016	1,006	975	984	1,000	991	1,011	994
Yakima	309	300	301	307	295	294	296	290
All RHCs	3,398	3,298	3,158	3,158	3,145	3,027	3,086	2,929

Note: All staff left Interlake School by end of July -- Interlake closed.

- In August 1994 there was a reduction to 2,929 total FTEs employed at RHCs, partly reflecting reductions due to the closure of Interlake school, and partly reflecting a general reduction in staffing at all RHCs. As of August 1994, total staffing at RHCs was 14% lower than it was in SFY 1990, and 22% lower than when staffing peaked in SFY 1992.

- Staffing at Interlake declined from January through May, then dropped off more sharply. It appears that there were still staff at the site through August, but actually all staff left at the end of July. There were still some staff listed for August 1994 in FRS since they were paid on August 10 for work performed during the last two weeks of July.

- Despite the closure of Interlake, staffing at other RHCs has not increased; rather, it has declined at all centers except Lakeland, which showed a mild increase during the past four months after a slight decline during January to March, 1994. Lakeland Village received the bulk of the individuals residing at Interlake, and thus hired some staff from Interlake to serve these persons. The increase in persons transferring to Lakeland for services, however, outpaced the staffing increase. Only 1.4 staff to each individual transferred were brought in during the past three months. This is particularly notable since the staff to persons served ratio at Lakeland tends to be around 2.3.

Table F-3: Staff Hours per Person Day by RHC

	Fiscal Year					5 Year %
Center	1990	1991	1992	1993	1994	Change
Fircrest	12.2	13.3	15.3	15.1	14.3	17.2
Interlake	11.3	13.3	15.8	14.4	14.3	26.5
Lakeland	10.7	12.9	13.5	13.1	13.1	22.4
FHMC	11.4	11.6	12.8	12.6	12.9	13.2
Rainier	10.5	12.6	12.6	12.6	12.3	17.1
Yakima	10.4	12.3	14.2	15.3	14.7	41.3
All RHCs	11.1	12.9	14.0	13.8	13.4	20.3

Note: All RHC row is a weighted average by facility size

- In general, staff hours per person day increased for each RHC, peaking in either SFY 1992 or SFY 1993 depending on the center, and have been on a declining trend since, with the exception of FHMC where the number of hours per person day increased slightly in SFY 1994. In contrast to other centers, FHMC has seen little change in the number of persons residing or staff working at the center over the past five years.

- By SFY 1994, Interlake had shown the greatest decline in the number of staff per person since its peak, followed by Fircrest, Yakima, Lakeland, and Rainier.

Table F-4 illustrates the effect of downsizing and transfers due to the closure of Interlake on staff hours per person day at the other RHCs during January through August, 1994.

Table F-4: RHC Staff Hours per Person Day, January to August 1994

	Calendar Year 1994							
Center	Jan	Feb	Mar	Apr	May	June	July	Aug
Fircrest	15.3	15.4	13.8	13.8	13.1	12.2	12.9	12.4
Interlake	13.7	13.8	13.4	16.3	23.9	32.3	0.0	0.0
Lakeland	13.8	13.8	13.4	12.8	13.1	12.8	13.0	12.5
FHMC	13.7	12.8	12.4	12.8	12.9	12.4	13.7	12.9
Rainier	12.3	12.2	11.8	11.9	12.1	12.1	12.3	12.1
Yakima	15.2	15.1	15.2	15.4	14.0	14.0	14.1	13.8
All RHCs	13.8	13.6	13.1	13.2	13.3	12.9	13.1	12.5

Note: All staff left Interlake School by end of July -- Interlake closed.

Note: Staff hours per person day for Interlake school are high during April, May, and June due to the movement of residents outpacing staffing reductions.

Note: All RHC row is a weighted average by facility size.

- There was no apparent impact of the closure of Interlake School and the resulting transfer of individuals and staff on the staffing levels for persons at the other centers. No center experienced a notable increase in staffing per person served during the eight-month span, and all centers had smaller staff to persons served ratios in August than they did during the beginning of the calendar year.

- By August 1994, Yakima Valley (13.8) and FHMC (12.9) had the highest numbers of staff hours per person day, with Lakeland (12.5), Fircrest (12.4), and Rainier (12.1) having lower numbers of hours.

- The staff hours per person day reported for Interlake during SFY 1994 are artificially high due to an artifact of the movement of individuals outpacing staffing reductions due to the closure of this facility. Persons in residence needed to leave the facility before staff could leave.

- The average hours per person day across RHCs for August 1994 was 12.5 hours for every individual in residence at an RHC. The decrease in staffing levels per person during recent months was due to the impact of the closure of Interlake School in July 1994, and to staffing reductions at other facilities.

APPENDIX G

STAFFING FOR GROUP HOMES

STAFFING FOR GROUP HOMES

The number of contracted FTEs for group homes are presented in Table G-1 by region. Counts include direct care staff only, and do not include other administrative and support personnel. Differences across regions are partially explained by the typical number of persons served per group home in the region.

Table G-1: Staffing Levels for Group Homes by Region

	July 1 contract					5 Year %
Region	1990	1991	1992	1993	1994	Change
Region 1	89	93	82	80	73	-17.9
Region 2	24	35	15	15	15	-40.0
Region 3	90	111	96	87	87	-3.7
Region 4	155	165	166	155	152	-2.0
Region 5	60	49	53	70	69	14.9
Region 6	134	129	107	105	103	-22.9
Statewide	552	582	518	511	499	-9.7

- Over the five-year span, the numbers of FTEs employed at group homes declined in all regions, except for Region 5.

- FTEs increased in SFY 1991 before declining in Regions 1, 2, and 3 (most of the drop in Region 2 occurred between SFY 1991 and SFY 1992); FTEs increased until SFY 1992 before declining in Region 4; and FTEs decreased every year in Region 6, particularly between SFY 1991 and 1992. Region 5 varied from year to year.

Table G-2 compares regions in terms of the number of contracted staff hours per person day for group homes. Values are weighted averages based on the number of contracted slots in each contract within a region, and the statewide values are weighted averages over the six regions.

Table G-2: Staff Hours per Person Day in Group Homes by Region

	July 1 contract					5 Year %
Region	**1990**	**1991**	**1992**	**1993**	**1994**	**Change**
Region 1	3.3	3.5	3.5	3.5	3.7	12.1
Region 2	4.0	4.5	4.2	4.2	4.2	5.0
Region 3	4.0	4.5	4.7	4.6	4.6	15.3
Region 4	4.5	4.7	4.8	4.7	5.2	15.0
Region 5	4.2	4.7	4.9	5.3	5.3	25.8
Region 6	3.0	3.0	3.1	3.1	3.1	2.6
Statewide	3.7	4.0	4.1	4.1	4.3	14.0

Note: Statewide row is a weighted average by regional program size.

- Although staffing declined, capacity in group homes declined at a faster rate, such that there were more direct care staff hours per person day in SFY 1994 than in SFY 1990.

- Region 5 experiencing the largest increase over the five-year span in staff hours per person day (26%). Other regions were slightly variable from year to year.

- Regions 1 and 6 have lower staff hours per person day than other regions (3.7 and 3.1 hours, respectively), and Regions 4 and 5 have higher staff hours per person day (5.2 and 5.3 hours, respectively).

APPENDIX H

STAFFING FOR ICF/MRs

STAFFING FOR ICF/MRs

The number of contracted FTEs for ICF/MRs are presented in Table H-1 by region. Counts include direct care staff only, and do not include other administrative and support personnel. Differences across regions are partially explained by the typical number of persons served per facility in the region.

Table H-1: Staffing Levels for ICF/MRs by Region

	July 1 contract					5 Year %
Region	1990	1991	1992	1993	1994	Change
Region 1	39	32	33	39	42	8.3
Region 2	55	9	10	10	11	-81.0
Region 3	29					-100.0
Region 4	345	333	289	265	235	-32.0
Region 5	73	71	77	85	77	4.5
Region 6	72	44	48	46	47	-34.7
Statewide	614	489	457	444	411	-33.0

- Region 3 had no contracts with ICF/MRs after SFY 1990.

- The number of contracted FTEs at ICF/MRs in Regions 1 and 5 were variable from year to year, and Region 2 experienced a large drop in contracted staff in SFY 1992 due to the closure of a large facility during SFY 1991.

- Region 6 experienced a decline in the number of contracted FTEs in SFY 1991, and varied in the number of FTEs thereafter, while Region 4 declined staffing every year as contracted slots declined.

Table H-2 compares regions in terms of the number of contracted staff hours per person day for ICF/MRs. Values are weighted averages based on the number of contracted slots in each contract within a region, and the statewide values are weighted averages over the six regions.

Table H-2: Staff Hours per Person Day in ICF/MRs by Region

	July 1 contract					5 Year %
Region	1990	1991	1992	1993	1994	Change
Region 1	4.5	4.6	4.8	5.7	6.0	32.7
Region 2	6.6	6.6	7.3	6.8	7.5	14.2
Region 3	4.9					-100.0
Region 4	6.1	6.6	7.6	7.6	8.4	37.8
Region 5	7.3	7.8	8.3	8.9	8.7	19.1
Region 6	4.6	5.5	6.3	6.1	6.4	38.3
Statewide	5.8	6.4	7.3	7.4	7.8	34.2

Note: Statewide row is a weighted average by regional program size.

- Direct care staff hours per person day increased in most years for all regions, except for slight declines in Region 5 during SFY 1994 and Region 6 during SFY 1993, and higher than expected number of hours in Region 2 during SFY 1992 based on the trend and level set by other years in the five-year span.

- Region 1 has a lower number of staff hours per person day than other regions (6.0 hours per person day in SFY 1994), and Region 5 has the highest number of staff hours per person day (8.7 hours per person day).

APPENDIX I

STAFFING FOR SUPPORTIVE LIVING

TOTAL STAFFING FOR SUPPORTIVE LIVING PROGRAMS

Table I-1 displays the total number of contracted FTEs for supportive living programs (i.e., alternative living, tenant support, intensive tenant support) by region. Counts include direct care staff only, and do not include other administrative and support personnel.

Table I-1: Total Staffing for Supportive Living By Region

	July 1 contract					4 Year %
Region	**1990**	**1991**	**1992**	**1993**	**1994**	**Change**
Region 1	-----	188	202	138	289	53.7
Region 2	-----	145	145	151	186	28.3
Region 3	-----	296	317	306	319	7.8
Region 4	-----	417	443	464	590	41.5
Region 5	-----	386	392	385	409	6.0
Region 6	-----	355	360	336	358	0.8
Statewide	-----	1,787	1,859	1,780	2,151	20.4

Note: Values for SFY 1990 have been omitted because contacts for alternative living and intensive tenant support programs were done differently prior to SFY 1991.

Note: % change is based on a 4 year time interval in this table, not 5 years as in other tables.

- The overall pattern in statewide staffing levels for supportive living programs has been variable from year to year; although, Regions 2 and 4 showed a consistent pattern of increasing numbers of contracted FTEs over the four-year span.

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STAFFING FOR ALTERNATIVE LIVING

After SFY 1990, some tenant support programs were combined with alternative living programs. The combined programs are referred to here as "Alternative Living" programs. The number of contracted FTEs for alternative living programs are presented in Table I-2 by region. Counts include direct care staff only, and do not include other administrative and support personnel. Because contracts for combined programs were not in place for the entire five-year span, a column for change over the five-year span has not been included in the tables.

Table I-2: Staffing Levels for Combined Tenant Support/ Alternative Living Programs by Region

	July 1 contract				
Region	1990	1991	1992	1993	1994
Region 1					7
Region 2		8	8	19	19
Region 3		3	4	24	25
Region 4		38	36	27	35
Region 5					15
Region 6					8
Statewide	0	50	49	70	109

- All regions now have combined tenant support/alternative living programs; however, prior to SFY 1994 only Regions 2, 3, and 4 had these programs, and then only since SFY 1991.

- The number of contracted FTEs at alternative living programs increased in Regions 2 and 3, particularly after SFY 1993 when several more contracted slots were added. The number of FTEs declined mildly in Region 4, dipping in SFY 1993, while the number of contracted slots increased mildly, except for the dip in contracted slots during SFY 1993.

Table I-3 compares regions in terms of the number of contracted staff hours per person day for combined tenant support/alternative living programs. Values are weighted averages based on the number of contracted slots in each contract within a region, and the statewide values are weighted averages over the six regions.

Table I-3: Staff Hours per Person Day for Combined Tenant Support/ Alternative Living Programs by Region

	July 1 contract				
Region	**1990**	**1991**	**1992**	**1993**	**1994**
Region 1					1.8
Region 2		1.5	1.5	1.2	1.2
Region 3		2.0	2.1	1.4	1.3
Region 4		1.2	1.2	1.0	1.1
Region 5					0.8
Region 6					0.9
Statewide		1.3	1.3	1.2	1.1

Note: Statewide row is a weighted average by regional program size.

- Regions 2, 3, and 4 were providing more hours per person day prior to SFY 1993 than they are currently providing. The drop in number of hours provided occurred primarily between SFY 1992 and SFY 1993 for these regions, with the largest drop occurring in Region 3.

- The number of hours per person day varies from year to year and from region to region. Regions 5 and 6 provided less than 1 hour per person day in SFY 1994, while Region 1 provided 1.8 hours per person day, although Region 3 had been even higher staffing ratios during SFY 1991 and 1992 (2 or more hours per person day).

STAFFING FOR TENANT SUPPORT

Although some tenant support programs have been combined with alternative living programs, several tenant support programs still offer only tenant support services. These programs are referred to here as "Tenant Support" programs. The number of contracted FTEs for tenant support programs are presented in Table I-4 by region. Counts include direct care staff only, and do not include other administrative and support personnel.

Table I-4: Staffing Levels for Tenant Support by Region

	July 1 contract					5 Year %
Region	1990	1991	1992	1993	1994	Change
Region 1	14	14	14	15	23	57.4
Region 2	20	11	10	6	6	-68.9
Region 3	16	18	18	4	4	-77.5
Region 4						
Region 5	18	18	18	26	6	-68.5
Region 6	16	19	17	10	10	-34.8
Statewide	85	80	76	62	49	-42.6

- There are no tenant support program contracts in Region 4.

- Since SFY 1990, the number of contracted FTEs for tenant support programs has declined by 35% or more in every region except for Region 1 where the number of contracted FTEs increased. These declines reflect the increase of combined tenant support/alternative living contracts.

- The higher number of FTEs in Region 2 during SFY 1990 and in Region 5 during SFY 1993, and the lower number of FTEs in Region 5 during SFY 1994 and in Regions 3 and 6 during SFY 1993 and SFY 1994 are a reflection of changes in the number of contracted slots for individuals; however, the higher number of FTEs in Region 1 during SFY 1994 was not related to a significant change in the number of contracted slots.

Table I-5 compares regions in terms of the number of contracted staff hours per person day for tenant support programs. Values are weighted averages based on the number of contracted slots in each contract within a region, and the statewide values are weighted averages over the six regions.

Table I-5: Staff Hours per Person Day for Tenant Support by Region

	July 1 contract					5 Year %
Region	1990	1991	1992	1993	1994	Change
Region 1	1.5	1.5	1.5	1.7	2.6	70.0
Region 2	1.5	1.5	1.5	1.4	1.4	-5.5
Region 3	1.5	1.5	1.5	1.4	1.4	-5.5
Region 4						
Region 5	1.5	1.5	1.5	1.0	1.4	-5.5
Region 6	1.5	1.7	1.6	1.5	1.5	6.6
Statewide	1.5	1.5	1.5	1.3	1.8	23.7

Note: Statewide row is a weighted average by regional program size.

- Direct care staff hours per person day increased in Region 1 during SFY 1993 and SFY 1994 as the number of contracted FTEs increased and the number of contracted slots changed very little. The high ratio in Region 1 also raised the statewide average for that year.

- The numbers of direct care staff hours per person day in tenant support programs were generally similar across regions at 1.5 hours per person during SFY 1990 to 1992, but were more variable in recent years.

STAFFING FOR INTENSIVE TENANT SUPPORT

The number of contracted FTEs for intensive tenant support are presented in Table I-6 by region. Counts include direct care staff only, and do not include other administrative and support personnel.

Table I-6: Staffing Levels for Intensive Tenant Support by Region

	July 1 contract					4 Year %	5 Year %
Region	1990	1991	1992	1993	1994	Change	Change
Region 1	88	174	188	123	259	49.2	194.2
Region 2	33	126	127	126	161	28.1	388.1
Region 3	144	275	295	278	290	5.7	101.7
Region 4	-----	379	407	437	555	46.3	-----
Region 5	318	368	374	359	388	5.5	21.9
Region 6	193	336	343	326	340	1.3	76.3
Statewide	-----	1,656	1,734	1,649	1,993	20.3	-----

Note: King County managed contracts for Region 4 during SFY 1990, so values for this region were not listed in the DDD Contract & Rate Files.

Note: % change is based on both 4 year and 5 year time intervals in this table. Because these programs were greatly expanded between SFY 1990 and SFY 1991, the four year estimate of change may be more accurate for planning purposes than the five year estimate.

- Region 4 increased staffing for intensive tenant support programs by 46% in four years.

- The number of contracted FTEs in other regions were variable from year to year. Staffing in Regions 1, 2, and 4 increased strongly in SFY 1994, reflecting sharp changes in the number of contracted slots for tenant support programs in these regions during this year.

Table I-7 compares regions in terms of the number of contracted staff hours per person day for intensive tenant support programs. Values are weighted averages based on the number of contracted slots in each contract within a region, and the statewide values are weighted averages over the six regions.

Table I-7: Staff Hours per Person Day for Intensive Tenant Support by Region

	July 1 contract					5 Year %
Region	1990	1991	1992	1993	1994	Change
Region 1	6.6	8.6	8.2	7.8	7.8	17.2
Region 2	4.8	7.9	7.5	7.9	8.1	70.1
Region 3	5.3	7.1	7.3	6.9	7.0	31.5
Region 4		9.9	10.0	9.7	10.1	-----
Region 5	10.0	9.9	10.1	9.4	9.4	-6.2
Region 6	6.6	8.5	8.4	7.9	7.8	18.1
Statewide	7.2	8.8	8.8	8.4	8.5	18.6

Note: Region 4 did not have any intensive tenant support contracts in SFY 1990.

Note: Statewide row is a weighted average by regional program size.

- The number of staff hours per person day increased in SFY 1991 for Regions 1, 2, 3, and 6, then was variable from year to year for Regions 2 and 3 and declined in Regions 1 and 6. Region 5 varied throughout the entire five-year span, as did Region 4 after SFY 1991.

- Region 3 provides a lower number of staff hours per person day than other regions (7.0 hours per person day in SFY 1994), and Regions 4 and 5 provide more staff hours per person day (9.4 and 10.1 hours, respectively, in SFY 1994).

APPENDIX J

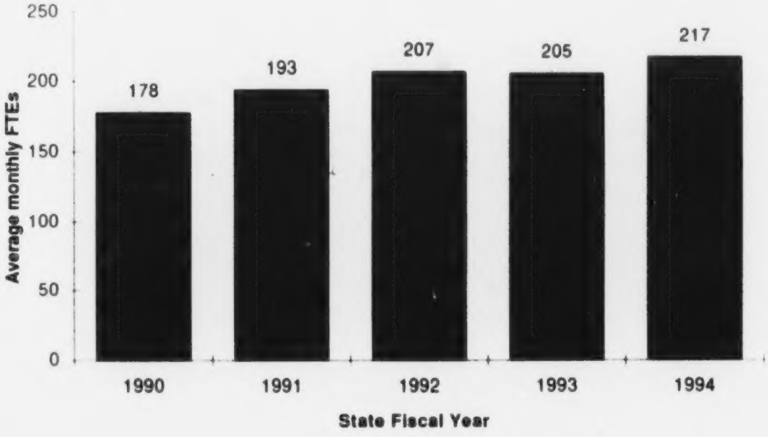
STAFFING AT REGIONAL FIELD SERVICE OFFICES

DDD operates 6 regional and 22 local field service offices around the state, which serve as the single point of intake and eligibility determination for all publicly funded developmental disabilities services in the state. The field service offices are responsible for developing and monitoring all community services contracted directly by the Division; for providing technical assistance to private contractors; and for coordinating planning and delivery of training services with county governments.

STAFFING AT REGIONAL FIELD SERVICE OFFICES BY REGION

The number of FTEs employed by field service offices statewide is shown in Figure J-1 by fiscal year. The number of FTEs includes case managers, administrative, and support personnel.

Figure J-1: Statewide Field Service Office Staffing



Note: Includes all field service office staff

- The number of field service office employees statewide has been increasing over the past five years from 178 FTEs during SFY 1990 to 217 during SFY 1994.

- In SFY 1994 there were 22% more employees at field service offices than in SFY 1990.

Table J-1: Staffing at Field Service Offices by Region

	Fiscal Year					5 Year %
Region	1990	1991	1992	1993	1994	Change
Region 1	28	33	34	33	35	24.7
Region 2	21	23	25	25	25	21.2
Region 3	25	27	30	29	32	30.4
Region 4	49	51	55	56	58	18.6
Region 5	29	30	32	33	34	18.0
Region 6	27	30	30	30	33	22.4
Statewide	178	193	207	205	217	22.0

Note: Includes all field service office staff.

- All regions have experienced increases in staffing since SFY 1990, although the rate of growth differed from region to region (see Table J-1).

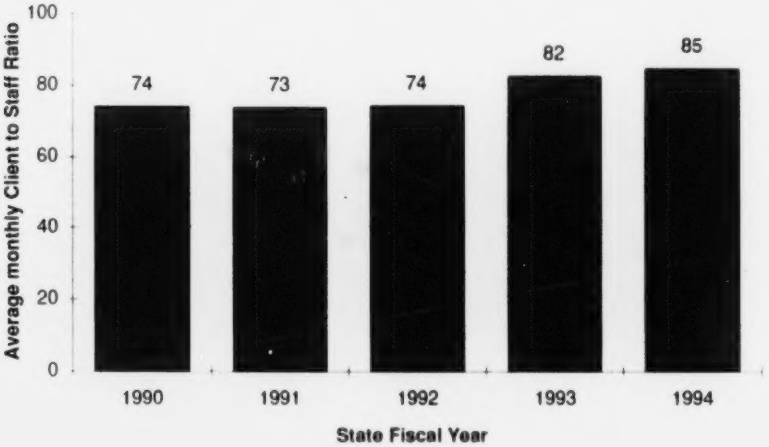
- Regions 4 and 5 have shown the lowest increase over SFY 1990 levels (19% and 18%, respectively). Region 3 has shown the highest rate of growth, increasing by more than 30%. These increases are considerably smaller than the 40% increase in the community caseload over the same time span.

CASELOADS PER STAFF MEMBER AT REGIONAL FIELD SERVICE OFFICES

Figure J-2 provides an estimate of the number of staff per person on the regional caseload at field service offices. Person to staff ratios were calculated by dividing the average daily number of persons eligible for services by the average monthly number of FTEs employed at field service offices within a given fiscal year (based on person months divided by 12). Because daily numbers were not available for FTEs, it was assumed that average daily FTE counts would not differ significantly from the average monthly counts.

The actual caseloads of case managers are higher than indicated here because some employees at field service offices do not work directly with individuals on the caseload. The counts also represent only individuals who have been determined eligible for DDD services. Persons who approach field service offices for eligibility determinations are not included in the counts. These persons require additional time and resources of field service office employees.

Figure J-2: Field Service Office Caseload to Staff Ratio



Note   Numbers are based on a ratio of all field service office staff to persons on the community caseload

- During SFY 1990 through SFY 1992 there were approximately 74 persons on the community caseload for every FTE in a regional field service office. This number is an underestimate of the number of persons per case manager because staffing counts include all regional field service office employees.

- The number of regional field service office employees per person rose in SFY 1993 and SFY 1994, such that there were 11 more persons per regional field service office FTE than there were two years earlier. Although both the number of persons on the community caseload and the number of field service office FTEs are increasing, community caseload growth is increasing faster than regional field service office employee growth, with the difference being greatest in the past two fiscal years.

Table J-2 compares regions in terms of the number of persons eligible for services per field service office employee. The statewide values are averages over the six regions.

Table J-2: Field Service Office Person to Staff Ratio by Region

	Fiscal Year					5 Year %
Region	1990	1991	1992	1993	1994	Change
Region 1	57.5	55.3	60.6	71.8	73.8	28.5
Region 2	66.6	67.5	66.5	75.1	79.9	20.0
Region 3	85.6	84.4	81.2	89.0	84.4	-1.4
Region 4	66.0	68.0	67.6	78.0	86.4	31.0
Region 5	87.6	89.0	88.0	92.8	95.5	9.0
Region 6	85.4	81.5	84.6	89.4	85.2	-0.2
Statewide	73.8	73.4	74.0	82.3	84.5	14.5

Note: Numbers are based on a ratio of all field service office staff to persons on the caseload.

Note: Statewide row is a weighted average by regional caseload.

- Regions 1, 2, 4, and 5 have shown increases since SFY 1993 in the number of persons on the caseload per field service office employee, with Regions 1 and 4 increasing the most over SFY 1990 levels. These increases were due to large increases in the number of persons eligible for services in the absence of similar staffing increases in these regions.
- The ratios in Regions 3 and 6 have varied unpredictably over the five-year span.
- Region 1 has the lowest caseload per field service employee (74 persons per FTE in SFY 1994), and Region 5 has consistently operated with the largest caseload per field service employee over the five-year span, currently at 95 persons per FTE.